
State: Arkansas **Filing Company:** American National Insurance Company
TOI/Sub-TOI: L04I Individual Life - Term/L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life
Product Name: ART12-DM
Project Name/Number: ART12-DM/ART12-DM

Filing at a Glance

Company: American National Insurance Company
Product Name: ART12-DM
State: Arkansas
TOI: L04I Individual Life - Term
Sub-TOI: L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life
Filing Type: Form
Date Submitted: 01/02/2013
SERFF Tr Num: AMNA-128680393
SERFF Status: Closed-Approved-Closed
State Tr Num:
State Status: Approved-Closed
Co Tr Num: ART12-DM

Implementation: On Approval
Date Requested:
Author(s): Tyra Reed, Amber Adams, Tobie Brink
Reviewer(s): Linda Bird (primary)
Disposition Date: 01/23/2013
Disposition Status: Approved-Closed
Implementation Date:

State Filing Description:

State: Arkansas **Filing Company:** American National Insurance Company
TOI/Sub-TOI: L04I Individual Life - Term/L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life
Product Name: ART12-DM
Project Name/Number: ART12-DM/ART12-DM

General Information

Project Name: ART12-DM Status of Filing in Domicile: Pending
 Project Number: ART12-DM Date Approved in Domicile:
 Requested Filing Mode: Review & Approval Domicile Status Comments:
 Explanation for Combination/Other: Market Type: Individual
 Submission Type: New Submission Individual Market Type:
 Overall Rate Impact: Filing Status Changed: 01/23/2013
 State Status Changed: 01/09/2013
 Deemer Date: Created By: Tobie Brink
 Submitted By: Tobie Brink Corresponding Filing Tracking Number:

Filing Description:
 January 2, 2013

Arkansas Insurance Department
 Compliance - Life and Health
 1200 West Third Street
 Little Rock AR 72201-1904

RE: American National Insurance Company (NAIC: 60739 FEIN: 74-0484030) Filing Of:
 Direct Marketing Term Life
 SERFF Tracking Number AMNA-128680393
 Company Tracking Number: ART12-DM

Dear Reviewer:

Form ART12(10), Form ART12-DP10, Form ART12-DP20, and Form ART12-DP30 were approved on 5/9/2012 under SERFF Tracking Number AMNA-128230158. Please find samples of each of these data pages under the supporting documentation tab to be used by our direct marketing channel to include direct mail, internet sales, and endorsed market. The minimum face amount is \$25,000.

Application 10582-AR will be used to apply for this product. This application replaces 10498-AR approved on 2/9/2012 under SERFF Tracking Number AMNA-127992033. The only changes made to the application was the removal of Apt. # and the addition of the statement "I have received and read the Summary and Disclosure Notice for Accelerated Benefits."

This application will also be used to apply for Form NPWL09DM(10) approved on 2/17/2010 under SERFF Tracking Number AMNA-126484400.

The following riders can be applied for:

- Children's Term Rider, Form CTR09DM, approved on 3/2/2010 under SERFF Tracking Number AMNA-126513629.
- Aviation Exclusion Rider, 1048XR, approved on 6/29/1982.
- Accelerated Benefit Rider – Terminal Illness, Form ABR11-TM, approved on 5/9/2011 under SERFF Tracking Number AMNA-127076498.

State: Arkansas **Filing Company:** American National Insurance Company
TOI/Sub-TOI: L04I Individual Life - Term/L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life
Product Name: ART12-DM
Project Name/Number: ART12-DM/ART12-DM

Accelerated Benefit Rider Forms – Supporting Documentation

•DMABR is the Summary and Disclosure Notice. This form will be provided at the time of application. The form must be returned to the Company with the completed application. The form provides various information regarding the benefit available, possible tax consequences, possible affect on receipt of public funds and other important information.

•Form ABR12DMEF(10) is the Accelerated Benefit Election Form that will be sent to the insured after reporting a qualifying condition and will include the offer to accelerate benefits. The form must be signed and returned to effectuate the acceleration. The form demonstrates the effect the acceleration of the death benefit(s) has on the policy and/or covered riders.

•DABRE is the Summary and Disclosure Notice provided to the Owner with the Accelerated Benefit Election Form. The form provides various information regarding the benefit available, possible tax consequences, possible affect on receipt of public funds and other important information. This form is sent with the Accelerated Benefit Election Form and requires that the Owner signs the form and return it with the Accelerated Benefit Election Form.

In order for a policy to be eligible for the terminal illness rider, there must be a minimum \$25,000 total death benefit. The accelerated death benefit rider will not be available on total death benefits exceeding \$1,000,000; this includes any previously issued policies with accelerated benefits.

This rider will be added at the time of application for new issues and available post issue for currently in-force business. This rider will be attached to and made part of the policy. There is no additional premium associated with these riders. An administrative fee, not to exceed \$500, will be deducted upon acceleration.

Additional information/supporting documentation included in this submission is as follows:

- Actuarial Memorandum for each plan
- Statement of Variability
- Readability Certification
- Sample policy summary
- As the above listed products are issued on a sex-distinct basis, we confirm that the policy will not be issued in any employer-employee plans that are subject to the Norris decision and/or Title VII of the Civil Rights Act of 1964.
- Payment of the required filing fees have been submitted via EFT.
- Any requirement for a third party authorization has been bypassed, as this is not a third-party filing.

Sincerely,

Tobie Brink
Life Policy Analyst III

Company and Contact

Filing Contact Information

Tobie Brink, Project Coordinator

Tobie.Brink@ANICO.com

State: Arkansas **Filing Company:** American National Insurance Company
TOI/Sub-TOI: L04I Individual Life - Term/L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life
Product Name: ART12-DM
Project Name/Number: ART12-DM/ART12-DM

One Moody Plaza 409-763-1112 [Phone] 4165 [Ext]
Actuarial Product Development 409-766-6933 [FAX]
14th Floor
Galveston, TX 77550

Filing Company Information

American National Insurance Company	CoCode: 60739	State of Domicile: Texas
One Moody Plaza	Group Code: 408	Company Type:
Galveston, TX 77550	Group Name:	State ID Number:
(409) 763-4661 ext. [Phone]	FEIN Number: 74-0484030	

Filing Fees

Fee Required?	Yes
Fee Amount:	\$50.00
Retaliatory?	Yes
Fee Explanation:	\$50 per exempt filing separate from a policy; based on TX domicile fee.
Per Company:	No

Company	Amount	Date Processed	Transaction #
American National Insurance Company	\$50.00	01/02/2013	66196186

SERFF Tracking #:	AMNA-128680393	State Tracking #:		Company Tracking #:	ART12-DM
State:	Arkansas	Filing Company:	American National Insurance Company		
TOI/Sub-TOI:	L04I Individual Life - Term/L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life				
Product Name:	ART12-DM				
Project Name/Number:	ART12-DM/ART12-DM				

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	01/23/2013	01/23/2013
Approved-Closed	Linda Bird	01/09/2013	01/09/2013

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Supporting Document	Direct Marketing Process, Online and Telephone Screen Shots	Tobie Brink	01/23/2013	01/23/2013

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Re-open	Note To Filer	Linda Bird	01/23/2013	01/23/2013
Re-open	Note To Reviewer	Tobie Brink	01/22/2013	01/22/2013

State:	Arkansas	Filing Company:	American National Insurance Company
TOI/Sub-TOI:	L04I Individual Life - Term/L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life		
Product Name:	ART12-DM		
Project Name/Number:	ART12-DM/ART12-DM		

Disposition

Disposition Date: 01/23/2013

Implementation Date:

Status: Approved-Closed

Comment: Company has made correction to the original submission.

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Life & Annuity - Acturial Memo		No
Supporting Document	Statements of Variability		Yes
Supporting Document	Certification of Compliance		Yes
Supporting Document	Cover Letter		Yes
Supporting Document	Sample Policy Summary		Yes
Supporting Document	Sample Data Pages		Yes
Supporting Document	ABR Election Form and Disclosures		Yes
Supporting Document	Direct Marketing Process, Online and Telephone Screen Shots		Yes
Form	Application for Individual Life Insurance		Yes

State:	Arkansas	Filing Company:	American National Insurance Company
TOI/Sub-TOI:	L04I Individual Life - Term/L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life		
Product Name:	ART12-DM		
Project Name/Number:	ART12-DM/ART12-DM		

Disposition

Disposition Date: 01/09/2013

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Life & Annuity - Acturial Memo		No
Supporting Document	Statements of Variability		Yes
Supporting Document	Certification of Compliance		Yes
Supporting Document	Cover Letter		Yes
Supporting Document	Sample Policy Summary		Yes
Supporting Document	Sample Data Pages		Yes
Supporting Document	ABR Election Form and Disclosures		Yes
Supporting Document	Direct Marketing Process, Online and Telephone Screen Shots		Yes
Form	Application for Individual Life Insurance		Yes

SERFF Tracking #:	AMNA-128680393	State Tracking #:		Company Tracking #:	ART12-DM
State:	Arkansas	Filing Company:	American National Insurance Company		
TOI/Sub-TOI:	L04I Individual Life - Term/L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life				
Product Name:	ART12-DM				
Project Name/Number:	ART12-DM/ART12-DM				

Amendment Letter

Submitted Date: 01/23/2013

Comments:

Good morning,

Thank you for re-opening the filing. Please find attached the direct marketing process, along with the screen shots of the electronic and telephone process.

Thank you,

Tobie Brink

Changed Items:

No Form Schedule Items Changed.

No Rate Schedule Items Changed.

Supporting Document Schedule Item Changes	
Satisfied - Item:	Direct Marketing Process, Online and Telephone Screen Shots
Comments:	
Attachment(s):	
ANICO Direct Process.pdf	
AR screen shots-call center.pdf	
AR screen shots-customer.pdf	

State: Arkansas **Filing Company:** American National Insurance Company
TOI/Sub-TOI: L04I Individual Life - Term/L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life
Product Name: ART12-DM
Project Name/Number: ART12-DM/ART12-DM

Note To Filer

Created By:

Linda Bird on 01/23/2013 08:47 AM

Last Edited By:

Linda Bird

Submitted On:

01/23/2013 08:47 AM

Subject:

Re-open

Comments:

Filing has been re-opened in order for correction to be made.

State: Arkansas **Filing Company:** American National Insurance Company
TOI/Sub-TOI: L04I Individual Life - Term/L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life
Product Name: ART12-DM
Project Name/Number: ART12-DM/ART12-DM

Note To Reviewer

Created By:

Tobie Brink on 01/22/2013 01:52 PM

Last Edited By:

Tobie Brink

Submitted On:

01/22/2013 01:52 PM

Subject:

Re-open

Comments:

Good afternoon,

Would you please re-open this filing so I may add the electronic and telephone screen shots.

Thank you,
Tobie Brink

State:	Arkansas	Filing Company:	American National Insurance Company
TOI/Sub-TOI:	L04I Individual Life - Term/L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life		
Product Name:	ART12-DM		
Project Name/Number:	ART12-DM/ART12-DM		

Form Schedule

Lead Form Number:								
Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1		Application for Individual Life Insurance	10582-AR	AEF	Initial		50.200	10582-AR.pdf

Form Type Legend:

ADV	Advertising	AEF	Application/Enrollment Form
CER	Certificate	CERA	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	FND	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	NOC	Notice of Coverage
OTH	Other	OUT	Outline of Coverage
PJK	Policy Jacket	POL	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	SCH	Schedule Pages



Application For Individual Life Insurance

American National Insurance Company

P.O. Box 696700
San Antonio, TX 78269

Your Details:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #1: (____) _____ Phone #2: (____) _____

E-mail: _____

Social Security Number: _____ - _____ - _____

Date of Birth: ____/____/____

☐ Female ☐ Male Height: ____ ft. ____ in. Weight: _____

Are you a U.S. Citizen? ☐ Yes ☐ No

If 'No', do you have a permanent residence status? ☐ Yes ☐ No

Annual Household Income: ☐ Under \$10,000 ☐ \$10,000 - \$24,999
☐ \$25,000 - \$49,999 ☐ \$50,000 - \$99,999 ☐ \$100,000+

Marital Status: ☐ Single ☐ Married

Have you smoked cigarettes in the last 12 months? ☐ Yes ☐ No

Occupation: _____

Your Amount of Coverage & Beneficiary:

Plan: _____

Amount (choose one):

☐ \$250,000

☐ \$150,000

☐ \$100,000

☐ Other: \$ _____

Beneficiary: _____

Date of Birth: ____/____/____ Relationship: _____

Automatic Premium Loan Provision Requested? ☐ Yes ☐ No

IMPORTANT: Do you intend to replace, discontinue, or change any existing life insurance policy? ☐ Yes ☐ No

If 'Yes', name of company and policy number(s) if available:

Your Health:

1. Within the past 10 years, have you been diagnosed or treated by a member of the medical profession for: heart attack, disease or abnormality of the heart or blood vessels, stroke, cerebral vascular accident (CVA), aneurysm, peripheral vascular disease, cancer (excluding basal and squamous cell skin cancer), leukemia, lymphoma, malignancy, nervous system disease or disorder, hepatitis C, kidney, liver, pancreas disease or disorder, Alzheimer's, schizophrenia, bipolar, mental disorder, or as having an acquired immune deficiency disease or disorder (AIDS), AIDS-Related Complex, or tested positive on an acquired immune deficiency syndrome-related test?

You ☐ Yes ☐ No

Your Spouse's Details (if applying):

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #1: (____) _____ Phone #2: (____) _____

E-mail: _____

Social Security Number: _____ - _____ - _____

Date of Birth: ____/____/____

☐ Female ☐ Male Height: ____ ft. ____ in. Weight: _____

Are you a U.S. Citizen? ☐ Yes ☐ No

If 'No', do you have a permanent residence status? ☐ Yes ☐ No

Annual Household Income: ☐ Under \$10,000 ☐ \$10,000 - \$24,999
☐ \$25,000 - \$49,999 ☐ \$50,000 - \$99,999 ☐ \$100,000+

Marital Status: ☐ Single ☐ Married

Have you smoked cigarettes in the last 12 months? ☐ Yes ☐ No

Occupation: _____

Your Spouse's Coverage & Beneficiary:

Plan: _____

Amount (choose one):

☐ \$250,000

☐ \$150,000

☐ \$100,000

☐ Other: \$ _____

Beneficiary: _____

Date of Birth: ____/____/____ Relationship: _____

Automatic Premium Loan Provision Requested? ☐ Yes ☐ No

IMPORTANT: Do you intend to replace, discontinue, or change any existing life insurance policy? ☐ Yes ☐ No

If 'Yes', name of company and policy number(s) if available:

Your Spouse's Health (if applying):

Your Spouse ☐ Yes ☐ No

Your Health:

2. Within the past 5 years, have you been: Diagnosed or treated by a member of the medical profession for a seizure or transient ischemic attack (TIA), hospitalized for depression or attempted suicide, diagnosed or treated by a member of the medical profession or received treatment or counseling for alcoholism, alcohol abuse or drug abuse, convicted of driving while intoxicated (DWI) or driving under the influence (DUI), convicted of a felony or been in prison?

You ☐ Yes ☐ No

Your Spouse's Health (if applying):

Your Spouse ☐ Yes ☐ No

3. Are you currently admitted to or confined to a hospital, mental institution, nursing home, assisted living center or receiving home health care or need assistance with eating, bathing or dressing?

You ☐ Yes ☐ No

Your Spouse ☐ Yes ☐ No

4. Within the past 10 years, have you been diagnosed or treated by a member of the medical profession for: musculoskeletal disorder, lupus, connective tissue disease, lung disease or disorder, clotting or bleeding disorder, anemia or blood disease, diabetes treated with insulin or requiring hospitalization, high blood pressure requiring more than 2 medications or hospitalization? If “Yes”, provide details below (dates of treatment, test results, diagnoses, medications, etc.)

You ☐ Yes ☐ No Details: _____

Your Spouse ☐ Yes ☐ No Details: _____

5. Within the past 60 days, have you been advised by a member of the medical profession to get specified medical care which has not yet been completed or are still awaiting results, such as any hospitalization, surgery or diagnostic test, except those tests related to the Human Immunodeficiency Virus (AIDS virus)? If "Yes", provide details below:

You ☐ Yes ☐ No Details: _____

Your Spouse ☐ Yes ☐ No Details: _____

If you have more details, please include them on a separate sheet of paper

Your Payment — choose one:

I/we authorize the collection of premiums for the policy or policies as follows.

1. ☐ Automatic monthly deductions from my checking or savings account.

(Enclose a voided check when providing checking account and a deposit slip when providing savings account.)

2. ☐ Charge monthly premiums to my: ☐ Visa ☐ MasterCard ☐ Discover

--	--

3. ☐ Bill me/us. (Send no money now.)

(Account Number)

(Exp. Date)

Agreements and Your Authorization to Obtain, Release and Disclose Medical Information:

I understand and agree: that the answers in this application are, to the best of my knowledge and belief, complete and true; that the answers will be relied upon to determine if coverage will be issued and the amount of premium that will be charged and will become a part of the Policy; that any material misstatement or omissions may cause the policy to be void; that the Company will have no liability until a policy is issued and the first premium due is paid in full while I am alive and in the same health condition as described above; that if my spouse and I request life insurance on this application that my personal financial and health information written on it will be made part of the policy issued to not only me but also my spouse; and that if I do not agree, I may contact the Company and receive a separate application.

I authorize any physician, medical practitioner, hospital, clinic, pharmacy, pharmacy benefit manager or other medical-related facility, insurance company, MIB, Inc. or other organization that has any records concerning health or medical care, advice or treatment provided to me to give any such information to American National Insurance Company, or to any agent or agency acting on its behalf or to its reinsurer(s). I authorize the Company, or its reinsurers, to make a brief report of my personal health information to MIB,

Your Signature: X _____

Date: X / /

Inc. I understand: that the Company will use this information to determine my eligibility for life insurance and the premium amount; that I may refuse to sign this authorization and that my refusal will affect my ability to obtain insurance; that such information may be subject to redisclosure and if so may no longer be protected by federal privacy law; that this authorization shall be valid for 24 months from the date signed and a copy will be as valid as the original; and that I have the right to revoke this authorization at any time, except to the extent that action has been taken in reliance thereon, by sending written notice to: the Company at the above address.

- ☒ I have read the Consumer Disclosure on the Sale of Insurance accompanying this application.

- I acknowledge receiving the Exchange of Information Notice.

- ☒ I have received and read the Summary and Disclosure Notice for Accelerated Benefits.

- **Fraud Warning:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Your Spouse's Signature: X_____

Date: X / /

State:	Arkansas	Filing Company:	American National Insurance Company
TOI/Sub-TOI:	L04I Individual Life - Term/L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life		
Product Name:	ART12-DM		
Project Name/Number:	ART12-DM/ART12-DM		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification		
Comments:			
Attachment(s):			
AR Readability Certification.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Application		
Comments:	The application is submitted for approval under the Form Schedule tab.		

		Item Status:	Status Date:
Satisfied - Item:	Life & Annuity - Acturial Memo		
Comments:			
Attachment(s):			
Form ART12-DP10 Actuarial Memo.pdf			
Form ART12-DP20 Actuarial Memo.pdf			
Form ART12-DP30 Actuarial Memo.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Statements of Variability		
Comments:			
Attachment(s):			
10582-AR Statement of Variability.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Certification of Compliance		
Comments:			
Attachment(s):			

State:	Arkansas	Filing Company:	American National Insurance Company
TOI/Sub-TOI:	L04I Individual Life - Term/L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life		
Product Name:	ART12-DM		
Project Name/Number:	ART12-DM/ART12-DM		

AR - Certification of Compliance.pdf

		Item Status:	Status Date:
Satisfied - Item:	Cover Letter		
Comments:			
Attachment(s):			
AR.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Sample Policy Summary		
Comments:			
Attachment(s):			
Sample Policy Summary.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Sample Data Pages		
Comments:			
Attachment(s):			
Form ART12-DP10 AR.pdf Form ART12-DP20 AR.pdf Form ART12-DP30 AR.pdf			

		Item Status:	Status Date:
Satisfied - Item:	ABR Election Form and Disclosures		
Comments:			
Attachment(s):			
Form ABR12DMEF(10).pdf DABRE.pdf DMABR.pdf			

		Item Status:	Status Date:
--	--	--------------	--------------

State:	Arkansas	Filing Company:	American National Insurance Company
TOI/Sub-TOI:	L04I Individual Life - Term/L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life		
Product Name:	ART12-DM		
Project Name/Number:	ART12-DM/ART12-DM		

Satisfied - Item:	Direct Marketing Process, Online and Telephone Screen Shots		
Comments:			
Attachment(s):			
ANICO Direct Process.pdf AR screen shots-call center.pdf AR screen shots-customer.pdf			



READABILITY CERTIFICATION

We hereby certify that the following form(s), meet the requirements of the Readability Insurance Policies Act:

<u>Form</u>	<u>Form Name</u>	<u>Scoring(s)</u>
10582-AR	Application for Individual Life Insurance	50.2

Rex D. Hemme
Senior Vice President & Actuary
American National Insurance Company
12/17/2012

AMERICAN NATIONAL INSURANCE COMPANY

ACTUARIAL MEMORANDUM

Form ART12-DP10

Purpose and Scope

This actuarial memorandum has been prepared to support the filing of a new 10 year guaranteed level premium term life insurance product with premiums increasing annually after the level period to age 95. This new rate scale is intended for simplified issue direct solicitation in the form of direct mail, internet sales, and endorsed (sponsored) market sales. The direct solicitation product version does not replace the agent solicited fully underwritten or worksite marketing simplified issue product versions already approved under Form ART12-DP10. This document has been prepared for the purpose of demonstrating compliance with regulatory authorities and may not be appropriate for other purposes.

Product Description

Policy Benefits:

This term product is a non-participating term insurance product with a level death benefit payable to age 95. There are no nonforfeiture benefits required based upon calculations made using the NAIC Standard Nonforfeiture Law for Life Insurance, model #808.

Issue Age Range:

Issue age range is age last birthday 18 to 64.

Face Amount Range:

The minimum face amount is \$25,000 and the maximum face amount is \$250,000.

Premium rates for this product are not banded.

Rate Classes:

The rate classes available are Standard Non-Nicotine User and Standard Nicotine User.

Premiums:

Premiums vary by issue age, sex, duration, and nicotine use classification. A policy fee of \$ 60 is added to the premium in all policy years. The policyowner will be charged premiums based on the current premium scale in effect. However, the current premium scale will never exceed the guaranteed premium scale specified in the policy.

The current premiums are level for 10 years. The current premiums are guaranteed for the level period. Beginning in the first policy year after the initial guarantee period, the current premiums and guaranteed premiums increase annually. Premiums are payable to age 95.

Participating:

This product is non-participating.

Nonforfeiture Benefits

The product was tested for nonforfeiture values under the NAIC Nonforfeiture Law for Life Insurance, model #808, for all ages, rate classes, and durations. Based on a unitary basis for both current and guaranteed premiums, no nonforfeiture values develop. Therefore, there are no nonforfeiture values required under this policy form.

Mortality Tables and Interest Assumption

Calculations are based on a 4% interest rate, semi-continuous functions, and the 2001 CSO Sex and Smoker Distinct Ultimate ALB mortality tables.

Minimum Nonforfeiture Demonstration

Symbols used in Nonforfeiture Demonstration

AAI	The Average Amount of Insurance for the first 10 policy years
r	Constant Percentage adjusted premium multiple of gross premium
$GP_{[x]+t}$	Gross premium per unit for unit for issue age x , $0 \leq t \leq 94 - x$
${}_tSNFLCV_x$	The minimum nonforfeiture cash value at the end of year t for issue age x as calculated under Standard Nonforfeiture Law

Minimum Cash Value under Standard Nonforfeiture Law Unitary Method

1. Net Level Premium

$$P_x \left(\overline{A}_{x:95-x|}^{-1} \right) = \frac{\overline{A}_{x:95-x|}^{-1}}{\ddot{a}_{x:95-x|}} = \frac{\frac{\overline{M}_x - \overline{M}_{95}}{D_x}}{\frac{N_x - N_{95}}{D_x}}$$

2. Expense Allowance

$$EA_x = 0.01 * AAI + 1.25 * \min \left(P_x \left(\overline{A}_{x:95-x|}^{-1} \right), 0.04 * AAI \right)$$

3. Adjusted Premium

$$P_{[x]+t}^A = r * GP_{[x]+t}$$

$$r = \frac{\overline{A}_{x:95-x}^{-1} + EA_x}{\sum_{t=0}^{95-x} (GP_{[x]+t} * D_{[x]+t}) D_x}$$

The “r” is the constant percentage.

4. Nonforfeiture Cash Values

$$\begin{aligned} {}_tSNFLCV_x &= \overline{A}_{x+t:95-x}^{-1} - \frac{\sum_{x+t}^{95-(x+t)} (P_{x+t}^A * D_{x+t})}{D_{x+t}} \\ &= \left(\frac{\overline{M}_{x+t} - \overline{M}_{95}}{D_{x+t}} \right) - \frac{\sum_{x+t}^{95-(x+t)} (r * GP_{[x]+t} * D_{x+t})}{D_{x+t}} \end{aligned}$$

Minimum Nonforfeiture Cash Value

$${}_tNFCV_x = \text{Max}({}_tSNFLCV_x, 0)$$

Nonforfeiture Cash Value Exemption

Nonforfeiture values are not required if ${}_tNFCV_x < 2.5\%$ of policy face amount in all years.

Numerical Demonstrations

Appendix 1 contains a tabular minimum cash value demonstration. Appendix 2 contains sample nonforfeiture calculations. Appendix 3 contains the premiums used in the demonstration.

Reserves

Minimum reserves will be calculated according to the NAIC Valuation of Life Insurance Policies Model Regulation (Regulation XXX) which defines the Commissioners’ Reserve Valuation Method (CRVM) for policies with non-level guaranteed gross premiums.

Basis for Basic Reserves

Basic Reserves will be calculated as the greater of the segmented reserves and the unitary reserves. Both segmented and unitary reserves will be calculated using 2001 CSO Sex and Smoker Distinct select and ultimate

ALB mortality tables using continuous functions. The interest rate used to calculate the reserves will be the maximum valuation interest rate permissible, which will be 3.5% beginning in January 2013.

Basis for Minimum Reserves

The minimum reserves, which will be calculated to determine the deficiency reserves, will be determined using the 2001 CSO Sex and Smoker Distinct select and ultimate ALB mortality tables, the appropriate X Factors, the maximum allowable valuation interest rate (3.5% beginning in January 2013), and continuous functions. X factors will be determined in accordance with the valuation regulation and will satisfy all of the required provisions. X factors will vary by policy factors expected to affect mortality experience. A complete list of X factors is on file at the home office.


Actuarial Certification

I hereby certify, to the best of my knowledge and judgment, that:

1. The product was tested for nonforfeiture values under the NAIC Standard Nonforfeiture Law for Life Insurance, model #808, for all ages, rate classes, and durations. Based on a unitary basis for both current and guaranteed premiums, no nonforfeiture values develop. Therefore, there are no nonforfeiture values required under this policy form.
2. The valuation standards used in establishing reserves for this policy form comply with the NAIC Standard Valuation Law and all applicable NAIC Actuarial Guidelines.

Statement of Professional Qualifications

I, Yau-Keung Terrence To, am an Advanced Actuarial Associate at American National Insurance Company and I am a member in good standing of the American Academy of Actuaries.



Yau-Keung Terrence To, ASA, MAAA
November 6, 2012

Appendix I

Tabular Nonforfeiture Cash Value Demonstration

(Values shown are per \$ 1,000 of Death Benefit and are based on current premium rate scale.)

Sample Insured: \$ 100,000 10-Year Level Premium Policy Issued to a 35 Year-Old Male Standard Non-Nicotine User risk

End of Policy Year	Attained Age	PV of Guaranteed Death Benefit (1)	PV of Adjusted Premiums (2)	Nonforfeiture Cash Value (1) - (2)
1	36	211.86	234.97	-23.11
2	37	219.40	243.34	-23.94
3	38	227.19	252.07	-24.88
4	39	235.23	261.19	-25.96
5	40	243.55	270.71	-27.16
6	41	252.12	280.65	-28.52
7	42	260.96	291.04	-30.08
8	43	270.04	301.91	-31.88
9	44	279.36	313.30	-33.95
10	45	288.92	325.24	-36.32
11	46	298.71	336.48	-37.77
12	47	308.76	348.09	-39.33
13	48	319.11	360.09	-40.98
14	49	329.80	372.46	-42.67
15	50	340.82	385.22	-44.40
16	51	352.14	398.38	-46.23
17	52	363.76	411.96	-48.20
18	53	375.63	425.98	-50.35
19	54	387.74	440.46	-52.72
20	55	400.04	455.44	-55.41
21	56	412.50	470.94	-58.44
22	57	425.15	486.91	-61.76
23	58	438.01	503.36	-65.34
24	59	451.12	520.32	-69.20
25	60	464.44	537.83	-73.39
26	61	477.91	555.85	-77.94
27	62	491.46	574.39	-82.93

End of Policy Year	Attained Age	PV of Guaranteed Death Benefit (1)	PV of Adjusted Premiums (2)	Nonforfeiture Cash Value (1) - (2)
28	63	505.04	593.45	-88.41
29	64	518.60	613.08	-94.47
30	65	532.18	633.33	-101.15
31	66	545.77	654.30	-108.53
32	67	559.42	676.09	-116.67
33	68	573.13	698.80	-125.68
34	69	586.91	722.54	-135.63
35	70	600.74	747.43	-146.69
36	71	614.52	773.59	-159.07
37	72	628.14	801.17	-173.03
38	73	641.47	830.38	-188.91
39	74	654.52	861.54	-207.03
40	75	667.26	895.03	-227.77
41	76	679.64	930.42	-250.78
42	77	691.58	966.25	-274.68
43	78	702.88	999.26	-296.38
44	79	713.35	1025.99	-312.64
45	80	722.79	1043.95	-321.16
46	81	730.99	1055.81	-324.82
47	82	737.70	1065.53	-327.83
48	83	742.70	1072.76	-330.06
49	84	745.59	1076.90	-331.31
50	85	745.74	1077.04	-331.30
51	86	742.31	1071.92	-329.61
52	87	734.11	1059.82	-325.71
53	88	719.51	1038.32	-318.80
54	89	696.16	1003.97	-307.80
55	90	660.63	951.73	-291.10
56	91	608.11	874.67	-266.56
57	92	531.41	762.15	-230.73
58	93	418.87	597.00	-178.12
59	94	251.86	351.84	-99.98

Appendix 2

Sample Nonforfeiture Calculations

Sample Insured: \$ 100,000 10-Year Level Premium Policy Issued to a 35 Year-Old Male Standard Non-Nicotine User risk
Values shown are per \$ 1,000 of Death Benefit.

Minimum Cash Value under Standard Nonforfeiture Law Unitary Method

1. Net Level Premium

$$P_{35} \left(\bar{A}_{35:\overline{60}|}^1 \right) = \frac{\frac{\bar{M}_{35} - \bar{M}_{95}}{D_{35}}}{\frac{N_{35} - N_{95}}{D_{35}}} = \frac{204.58029}{20.68443} = 9.89054$$

2. Expense Allowance

$$\begin{aligned} EA_{35} &= 0.01 * AAI + 1.25 * \text{Min} \left(P_{35} \left(\bar{A}_{35:\overline{60}|}^1 \right), 0.04 * AAI \right) \\ &= 0.01 * 1000 + 1.25 * \text{Min} (9.89054, 0.04 * 1000) = 22.36318 \end{aligned}$$

3. Adjusted Premium

$$\begin{aligned} r &= \frac{\bar{A}_{35:\overline{60}|}^1 + EA_{35}}{\frac{\sum_{t=0}^{95-x} (GP_{[35]+3} * D_{[35]+3})}{D_{35}}} = \frac{204.58029 + 22.36318}{334.19957} = 0.67907 \\ P_{[35]+3}^A &= r * GP_{[35]+3} = 0.67907 * 1.86 = 1.26 \end{aligned}$$

4. Nonforfeiture Cash Values

$$\begin{aligned} {}_3SNFLCV_{35} &= \left(\frac{\bar{M}_{38} - \bar{M}_{95}}{D_{38}} \right) - \frac{\sum_{38}^{56} (r * GP_{[35]+3} * D_{38})}{D_{38}} \\ &= \left(\frac{201.25830}{0.88586} \right) - \frac{223.30219}{0.88586} = 227.18974 - 252.07391 = -24.88417 \end{aligned}$$

Minimum Nonforfeiture Cash Value

$$\begin{aligned} {}_3NFCV_{35} &= -24.88417 \\ {}_3NFCV_{35} &= \text{Max}(-24.88417, 0) \\ {}_3NFCV_{35} &= 0.00 \end{aligned}$$

Appendix 3

Numerical Demonstration Current Scale Gross Premiums

\$ 100,000 10-Year Level Premium Policy Issued to a 35 Year-Old Male Standard Non-Nicotine User risk

t	Gross Premium Per \$1000 w/o Policy Fee	t	Gross Premium Per \$1000 w/o Policy Fee
0	1.86	30	21.21
1	1.86	31	23.23
2	1.86	32	25.33
3	1.86	33	27.56
4	1.86	34	30.06
5	1.86	35	32.97
6	1.86	36	36.52
7	1.86	37	40.66
8	1.86	38	45.02
9	1.86	39	49.70
10	3.67	40	55.96
11	3.93	41	65.53
12	4.19	42	81.00
13	4.46	43	102.38
14	4.78	44	127.67
15	5.13	45	149.56
16	5.53	46	166.48
17	5.99	47	184.42
18	6.50	48	204.03
19	7.07	49	225.85
20	7.73	50	250.13
21	8.53	51	276.82
22	9.37	52	305.69
23	10.20	53	336.38
24	11.17	54	368.58
25	12.35	55	400.49
26	13.80	56	432.07
27	15.48	57	465.20
28	17.30	58	500.16
29	19.23	59	518.12

AMERICAN NATIONAL INSURANCE COMPANY

ACTUARIAL MEMORANDUM

Form ART12-DP20

Purpose and Scope

This actuarial memorandum has been prepared to support the filing of a new 20 year guaranteed level premium term life insurance product with premiums increasing annually after the level period to age 95. This new rate scale is intended for simplified issue direct solicitation in the form of direct mail, internet sales, and endorsed (sponsored) market sales. The direct solicitation product version does not replace the agent solicited fully underwritten or worksite marketing simplified issue product versions already approved under Form ART12-DP20. This document has been prepared for the purpose of demonstrating compliance with regulatory authorities and may not be appropriate for other purposes.

Product Description

Policy Benefits:

This term product is a non-participating term insurance product with a level death benefit payable to age 95. There are no nonforfeiture benefits required based upon calculations made using the NAIC Standard Nonforfeiture Law for Life Insurance, model #808.

Issue Age Range:

Issue age range is age last birthday 18 to 60.

Minimum Face Amount:

The minimum face amount is \$ 25,000, and the maximum face amount is \$ 250,000.

Premium rates for this product are not banded.

Rate Classes:

The rate classes available are Standard Non-Nicotine User and Standard Nicotine User.

Premiums:

Premiums vary by issue age, sex, duration, and nicotine use classification. A policy fee of \$ 60 is added to the premium in all policy years. The policyowner will be charged premiums based on the current premium scale in effect. However, the current premium scale will never exceed the guaranteed premium scale specified in the policy.

The current premiums are level for 20 years. The current premiums are guaranteed for the level period. Beginning in the first policy year after the initial guarantee period, the current premiums and guaranteed premiums increase annually. Premiums are payable to age 95.

Participating:

This product is non-participating.

Nonforfeiture Benefits

The product was tested for nonforfeiture values under the NAIC Nonforfeiture Law for Life Insurance, model #808, for all ages, rate classes, and durations. Based on a unitary basis for both current and guaranteed premiums, no nonforfeiture values develop. Therefore, there are no nonforfeiture values required under this policy form.

Mortality Tables and Interest Assumption

Calculations are based on a 4% interest rate, semi-continuous functions, and the 2001 CSO Sex and Smoker Distinct Ultimate ALB mortality tables.

Minimum Nonforfeiture Demonstration

Symbols used in Nonforfeiture Demonstration

AAI	The Average Amount of Insurance for the first 10 policy years
r	Constant Percentage adjusted premium multiple of gross premium
$GP_{[x]+t}$	Gross premium per unit for unit for issue age x , $0 \leq t \leq 94 - x$
${}_tSNFLCV_x$	The minimum nonforfeiture cash value at the end of year t for issue age x as calculated under Standard Nonforfeiture Law

Minimum Cash Value under Standard Nonforfeiture Law Unitary Method

1. Net Level Premium

$$P_x \left(\overline{A}_{x:95-x|}^{-1} \right) = \frac{\overline{A}_{x:95-x|}^{-1}}{\ddot{a}_{x:95-x|}} = \frac{\overline{M}_x - \overline{M}_{95}}{\frac{D_x}{N_x - N_{95}}}$$

2. Expense Allowance

$$EA_x = 0.01 * AAI + 1.25 * \min \left(P_x \left(\overline{A}_{x:95-x|}^{-1} \right), 0.04 * AAI \right)$$

3. Adjusted Premium

$$P_{[x]+t}^A = r * GP_{[x]+t}$$

$$r = \frac{\overline{A}_{x:95-x}^{-1} + EA_x}{\sum_{t=0}^{95-x} (GP_{[x]+t} * D_{[x]+t})}$$

$$D_x$$

The “r” is the constant percentage.

4. Nonforfeiture Cash Values

$${}_tSNFLCV_x = \overline{A}_{x+t:95-x}^{-1} - \frac{\sum_{x+t}^{95-(x+t)} (P_{x+t}^A * D_{x+t})}{D_{x+t}}$$

$$= \left(\frac{\overline{M}_{x+t} - \overline{M}_{95}}{D_{x+t}} \right) - \frac{\sum_{x+t}^{95-(x+t)} (r * GP_{[x]+t} * D_{x+t})}{D_{x+t}}$$

Minimum Nonforfeiture Cash Value

$${}_tNFCV_x = \text{Max}({}_tSNFLCV_x, 0)$$

Nonforfeiture Cash Value Exemption

Nonforfeiture values are not required if ${}_tNFCV_x < 2.5\%$ of policy face amount in all years.

Numerical Demonstrations

Appendix 1 contains a tabular minimum cash value demonstration. Appendix 2 contains sample nonforfeiture calculations. Appendix 3 contains the premiums used in the demonstration.

Reserves

Minimum reserves will be calculated according to the NAIC Valuation of Life Insurance Policies Model Regulation (Regulation XXX) which defines the Commissioners’ Reserve Valuation Method (CRVM) for policies with non-level guaranteed gross premiums.

Basis for Basic Reserves

Basic Reserves will be calculated as the greater of the segmented reserves and the unitary reserves. Both segmented and unitary reserves will be calculated using 2001 CSO Sex and Smoker Distinct select and ultimate

ALB mortality tables using continuous functions. The interest rate used to calculate the reserves will be the maximum valuation interest rate permissible, which will be 3.5% beginning in January 2013.

Basis for Minimum Reserves

The minimum reserves, which will be calculated to determine the deficiency reserves, will be determined using the 2001 CSO Sex and Smoker Distinct select and ultimate ALB mortality tables, the appropriate X Factors, the maximum allowable valuation interest rate (3.5% beginning in January 2012), and continuous functions. X factors will be determined in accordance with the valuation regulation and will satisfy all of the required provisions. X factors will vary by policy factors expected to affect mortality experience. A complete list of X factors is on file at the home office.

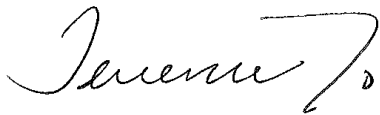
Actuarial Certification

I hereby certify, to the best of my knowledge and judgment, that:

1. The product was tested for nonforfeiture values under the NAIC Standard Nonforfeiture Law for Life Insurance, model #808, for all ages, rate classes, and durations. Based on a unitary basis for both current and guaranteed premiums, no nonforfeiture values develop. Therefore, there are no nonforfeiture values required under this policy form.
2. The valuation standards used in establishing reserves for this policy form comply with the NAIC Standard Valuation Law and all applicable NAIC Actuarial Guidelines.

Statement of Professional Qualifications

I, Yau-Keung Terrence To, am an Advanced Actuarial Associate at American National Insurance Company and I am a member in good standing of the American Academy of Actuaries.



Yau-Keung Terrence To, ASA, MAAA
November 6, 2012

Appendix I **Tabular Nonforfeiture Cash Value Demonstration**

(Values shown are per \$ 1,000 of Death Benefit and are based on current premium rate scale.)

Sample Insured: \$ 100,000 20-Year Level Premium Policy Issued to a 35 Year-Old Male Standard Non-Nicotine User risk

End of Policy Year	Attained Age	PV of Guaranteed Death Benefit (1)	PV of Adjusted Premiums (2)	Nonforfeiture Cash Value (1) - (2)
1	36	211.86	234.52	-22.66
2	37	219.4	242.43	-23.03
3	38	227.19	250.68	-23.49
4	39	235.23	259.29	-24.06
5	40	243.55	268.28	-24.73
6	41	252.12	277.67	-25.55
7	42	260.96	287.50	-26.54
8	43	270.04	297.78	-27.74
9	44	279.36	308.54	-29.18
10	45	288.92	319.83	-30.91
11	46	298.71	331.68	-32.97
12	47	308.76	344.10	-35.34
13	48	319.11	357.13	-38.02
14	49	329.8	370.77	-40.97
15	50	340.82	385.07	-44.25
16	51	352.14	400.10	-47.96
17	52	363.76	415.91	-52.15
18	53	375.63	432.59	-56.96
19	54	387.74	450.21	-62.47
20	55	400.04	468.88	-68.84
21	56	412.5	484.84	-72.34
22	57	425.15	501.28	-76.13
23	58	438.01	518.21	-80.20
24	59	451.12	535.68	-84.56
25	60	464.44	553.70	-89.26
26	61	477.91	572.26	-94.35
27	62	491.46	591.34	-99.88

End of Policy Year	Attained Age	PV of Guaranteed Death Benefit	PV of Adjusted Premiums	Nonforfeiture Cash Value
		(1)	(2)	(1) - (2)
28	63	505.04	610.96	-105.92
29	64	518.60	631.17	-112.57
30	65	532.18	652.02	-119.84
31	66	545.77	673.61	-127.84
32	67	559.42	696.04	-136.62
33	68	573.13	719.42	-146.29
34	69	586.91	743.87	-156.96
35	70	600.74	769.49	-168.75
36	71	614.52	796.42	-181.90
37	72	628.14	824.81	-196.67
38	73	641.47	854.89	-213.42
39	74	654.52	886.97	-232.45
40	75	667.26	921.44	-254.18
41	76	679.64	957.88	-278.24
42	77	691.58	994.76	-303.18
43	78	702.88	1028.74	-325.86
44	79	713.35	1056.27	-342.92
45	80	722.79	1074.76	-351.97
46	81	730.99	1086.96	-355.97
47	82	737.70	1096.97	-359.27
48	83	742.70	1104.41	-361.71
49	84	745.59	1108.68	-363.09
50	85	745.74	1108.82	-363.08
51	86	742.31	1103.55	-361.24
52	87	734.11	1091.10	-356.99
53	88	719.51	1068.96	-349.45
54	89	696.16	1033.59	-337.43
55	90	660.63	979.81	-319.18
56	91	608.11	900.48	-292.37
57	92	531.41	784.63	-253.22
58	93	418.87	614.61	-195.74
59	94	251.86	362.22	-110.36

Appendix 2

Sample Nonforfeiture Calculations

Sample Insured: \$ 100,000 20-Year Level Premium Policy Issued to a 35 Year-Old Male Standard Non-Nicotine User risk
Values shown are per \$ 1,000 of Death Benefit.

Minimum Cash Value under Standard Nonforfeiture Law Unitary Method

1. Net Level Premium

$$P_{35} \left(\bar{A}_{35:\overline{60}|}^1 \right) = \frac{\frac{\bar{M}_{35} - \bar{M}_{95}}{D_{35}}}{\frac{N_{35} - N_{95}}{D_{35}}} = \frac{204.58049}{20.68443} = 9.89054$$

2. Expense Allowance

$$\begin{aligned} EA_{35} &= 0.01 * AAI + 1.25 * \min \left(P_{35} \left(\bar{A}_{35:\overline{60}|}^1 \right), 0.04 * AAI \right) \\ &= 0.01 * 1000 + 1.25 * \min(9.89054, 0.04 * 1000) = 22.36318 \end{aligned}$$

3. Adjusted Premium

$$\begin{aligned} r &= \frac{\bar{A}_{35:\overline{60}|}^1 + EA_{35}}{\frac{\sum_{t=0}^{95-x} (GP_{[35]+3} * D_{[35]+3})}{D_{35}}} = \frac{204.58049 + 22.36318}{324.62053} = 0.69910 \\ P_{[35]+3}^A &= r * GP_{[35]+3} = 0.69910 * 2.42 = 1.69182 \end{aligned}$$

4. Nonforfeiture Cash Values

$$\begin{aligned} {}_3SNFLCV_{35} &= \left(\frac{\bar{M}_{38} - \bar{M}_{95}}{D_{38}} \right) - \frac{\sum_{38}^{56} (r * GP_{[35]+3} * D_{38})}{D_{38}} \\ &= \left(\frac{201.25830}{0.88586} \right) - \frac{222.06609}{0.88586} = 227.18925 - 250.6780 = -23.48875 \end{aligned}$$

Minimum Nonforfeiture Cash Value

$$\begin{aligned} {}_3NFCV_{35} &= -23.48875 \\ {}_3NFCV_{35} &= \max(-23.48875, 0) \\ {}_3NFCV_{35} &= 0.00 \end{aligned}$$

Appendix 3

Numerical Demonstration Current Scale Gross Premiums

\$ 100,000 20-Year Level Premium Policy Issued to a 35 Year-Old Male Standard Non-Nicotine User risk

t	Gross Premium Per \$1000 w/o Policy Fee	t	Gross Premium Per \$1000 w/o Policy Fee
0	2.42	30	21.21
1	2.42	31	23.23
2	2.42	32	25.33
3	2.42	33	27.56
4	2.42	34	30.06
5	2.42	35	32.97
6	2.42	36	36.52
7	2.42	37	40.66
8	2.42	38	45.02
9	2.42	39	49.70
10	2.42	40	55.96
11	2.42	41	65.53
12	2.42	42	81.00
13	2.42	43	102.38
14	2.42	44	127.67
15	2.42	45	149.56
16	2.42	46	166.48
17	2.42	47	184.42
18	2.42	48	204.03
19	2.42	49	225.85
20	7.73	50	250.13
21	8.53	51	276.82
22	9.37	52	305.69
23	10.20	53	336.38
24	11.17	54	368.58
25	12.35	55	400.49
26	13.80	56	432.07
27	15.48	57	465.20
28	17.30	58	500.16
29	19.23	59	518.12

AMERICAN NATIONAL INSURANCE COMPANY

ACTUARIAL MEMORANDUM

Form ART12-DP30

Purpose and Scope

This actuarial memorandum has been prepared to support the filing of a new 30 year guaranteed level premium term life insurance product with premiums increasing annually after the level period to age 95. This new rate scale is intended for simplified issue direct solicitation in the form of direct mail, internet sales, and endorsed (sponsored) market sales. The direct solicitation product version does not replace the agent solicited fully underwritten or worksite marketing simplified issue product versions already approved under Form ART12-DP30. This document has been prepared for the purpose of demonstrating compliance with regulatory authorities and may not be appropriate for other purposes.

Product Description

Policy Benefits:

This term product is a non-participating term insurance product with a level death benefit payable to age 95. There are no nonforfeiture benefits required based upon calculations made using the NAIC Standard Nonforfeiture Law for Life Insurance, model #808.

Issue Age Range:

Issue age range is age last birthday 18 to 50.

Minimum Face Amount:

The minimum face amount is \$ 25,000, and the maximum face amount is \$ 250,000.

Premium rates for this product are not banded.

Rate Classes:

The rate classes available are Standard Non-Nicotine User and Standard Nicotine User.

Premiums:

Premiums vary by issue age, sex, duration, nicotine use classification. A policy fee of \$ 60 is added to the premium in all policy years. The policyowner will be charged premiums based on the current premium scale in effect. However, the current premium scale will never exceed the guaranteed premium scale specified in the policy.

The current premiums are level for 30 years. The current premiums are guaranteed for the level period. Beginning in the first policy year after the initial guarantee period, the current premiums and guaranteed premiums increase annually. Premiums are payable to age 95.

Participating:

This product is non-participating.

Nonforfeiture Benefits

The product was tested for nonforfeiture values under the NAIC Nonforfeiture Law for Life Insurance, model #808, for all ages, rate classes, and durations. Based on a unitary basis for both current and guaranteed premiums, no nonforfeiture values develop. Therefore, there are no nonforfeiture values required under this policy form.

Mortality Tables and Interest Assumption

Calculations are based on a 4% interest rate, semi-continuous functions, and the 2001 CSO Sex and Smoker Distinct Ultimate ALB mortality tables.

Minimum Nonforfeiture Demonstration

Symbols used in Nonforfeiture Demonstration

AAI	The Average Amount of Insurance for the first 10 policy years
r	Constant Percentage adjusted premium multiple of gross premium
$GP_{[x]+t}$	Gross premium per unit for unit for issue age x , $0 \leq t \leq 94 - x$
${}_tSNFLCV_x$	The minimum nonforfeiture cash value at the end of year t for issue age x as calculated under Standard Nonforfeiture Law

Minimum Cash Value under Standard Nonforfeiture Law Unitary Method

1. Net Level Premium

$$P_x \left(\overline{A}_{x:95-x|}^{-1} \right) = \frac{\overline{A}_{x:95-x|}^{-1}}{\ddot{a}_{x:95-x|}} = \frac{\frac{\overline{M}_x - \overline{M}_{95}}{D_x}}{\frac{N_x - N_{95}}{D_x}}$$

2. Expense Allowance

$$EA_x = 0.01 * AAI + 1.25 * \min \left(P_x \left(\overline{A}_{x:95-x|}^{-1} \right), 0.04 * AAI \right)$$

3. Adjusted Premium

$$P_{[x]+t}^A = r * GP_{[x]+t}$$

$$r = \frac{\overline{A}_{x:95-x}^{-1} + EA_x}{\sum_{t=0}^{95-x} (GP_{[x]+t} * D_{[x]+t})}$$

$$D_x$$

The “r” is the constant percentage.

4. Nonforfeiture Cash Values

$${}_tSNFLCV_x = \overline{A}_{x+t:95-x}^{-1} - \frac{\sum_{x+t}^{95-(x+t)} (P_{x+t}^A * D_{x+t})}{D_{x+t}}$$

$$= \left(\frac{\overline{M}_{x+t} - \overline{M}_{95}}{D_{x+t}} \right) - \frac{\sum_{x+t}^{95-(x+t)} (r * GP_{[x]+t} * D_{x+t})}{D_{x+t}}$$

Minimum Nonforfeiture Cash Value

$${}_tNFCV_x = \text{Max}({}_tSNFLCV_x, 0)$$

Nonforfeiture Cash Value Exemption

Nonforfeiture values are not required if ${}_tNFCV_x < 2.5\%$ of policy face amount in all years.

Numerical Demonstrations

Appendix 1 contains a tabular minimum cash value demonstration. Appendix 2 contains sample nonforfeiture calculations. Appendix 3 contains the premiums used in the demonstration.

Reserves

Minimum reserves will be calculated according to the NAIC Valuation of Life Insurance Policies Model Regulation (Regulation XXX) which defines the Commissioners’ Reserve Valuation Method (CRVM) for policies with non-level guaranteed gross premiums.

Basis for Basic Reserves

Basic Reserves will be calculated as the greater of the segmented reserves and the unitary reserves. Both segmented and unitary reserves will be calculated using 2001 CSO Sex and Smoker Distinct select and ultimate ALB mortality tables using continuous functions. The interest rate used to calculate the reserves will be the maximum valuation interest rate permissible, which will be 3.5% beginning in January 2013.

Basis for Minimum Reserves

The minimum reserves, which will be calculated to determine the deficiency reserves, will be determined using the 2001 CSO Sex and Smoker Distinct select and ultimate ALB mortality tables, the appropriate X Factors, the maximum allowable valuation interest rate (3.5% beginning in January 2012), and continuous functions. X factors will be determined in accordance with the valuation regulation and will satisfy all of the required provisions. X factors will vary by policy factors expected to affect mortality experience. A complete list of X factors is on file at the home office.

Actuarial Certification

I hereby certify, to the best of my knowledge and judgment, that:

1. The product was tested for nonforfeiture values under the NAIC Standard Nonforfeiture Law for Life Insurance, model #808, for all ages, rate classes, and durations. Based on a unitary basis for both current and guaranteed premiums, no nonforfeiture values develop. Therefore, there are no nonforfeiture values required under this policy form.
2. The valuation standards used in establishing reserves for this policy form comply with the NAIC Standard Valuation Law and all applicable NAIC Actuarial Guidelines.

Statement of Professional Qualifications

I, Yau-Keung Terrence To, am an Advanced Actuarial Associate at American National Insurance Company and I am a member in good standing of the American Academy of Actuaries.



Yau-Keung Terrence To, ASA, MAAA
November 6, 2012

Appendix I

Tabular Nonforfeiture Cash Value Demonstration

(Values shown are per \$ 1,000 of Death Benefit and are based on current premium rate scale.)

Sample Insured: \$ 100,000 30-Year Level Premium Policy Issued to a 35 Year-Old Male Standard Non-Nicotine User risk

End of Policy Year	Attained Age	PV of Guaranteed Death Benefit (1)	PV of Adjusted Premiums (2)	Nonforfeiture Cash Value (1) - (2)
1	36	211.86	233.78	-21.92
2	37	219.4	240.91	-21.51
3	38	227.19	248.36	-21.17
4	39	235.23	256.13	-20.90
5	40	243.55	264.25	-20.70
6	41	252.12	272.73	-20.61
7	42	260.96	281.60	-20.64
8	43	270.04	290.89	-20.85
9	44	279.36	300.62	-21.26
10	45	288.92	310.83	-21.91
11	46	298.71	321.55	-22.84
12	47	308.76	332.80	-24.04
13	48	319.11	344.60	-25.49
14	49	329.8	356.95	-27.15
15	50	340.82	369.91	-29.09
16	51	352.14	383.53	-31.39
17	52	363.76	397.87	-34.11
18	53	375.63	413.00	-37.37
19	54	387.74	429.00	-41.26
20	55	400.04	445.97	-45.93
21	56	412.5	464.00	-51.50
22	57	425.15	483.19	-58.04
23	58	438.01	503.60	-65.59
24	59	451.12	525.32	-74.20
25	60	464.44	548.50	-84.06
26	61	477.91	573.34	-95.43
27	62	491.46	600.09	-108.63

End of Policy Year	Attained Age	PV of Guaranteed Death Benefit	PV of Adjusted Premiums	Nonforfeiture Cash Value
		(1)	(2)	(1) - (2)
28	63	505.04	629.03	-123.99
29	64	518.6	660.43	-141.83
30	65	532.18	694.55	-162.37
31	66	545.77	717.55	-171.78
32	67	559.42	741.45	-182.03
33	68	573.13	766.35	-193.22
34	69	586.91	792.39	-205.48
35	70	600.74	819.68	-218.94
36	71	614.52	848.37	-233.85
37	72	628.14	878.62	-250.48
38	73	641.47	910.65	-269.18
39	74	654.52	944.83	-290.31
40	75	667.26	981.54	-314.28
41	76	679.64	1020.36	-340.72
42	77	691.58	1059.65	-368.07
43	78	702.88	1095.85	-392.97
44	79	713.35	1125.17	-411.82
45	80	722.79	1144.87	-422.08
46	81	730.99	1157.87	-426.88
47	82	737.7	1168.53	-430.83
48	83	742.7	1176.46	-433.76
49	84	745.59	1181.00	-435.41
50	85	745.74	1181.16	-435.42
51	86	742.31	1175.54	-433.23
52	87	734.11	1162.27	-428.16
53	88	719.51	1138.69	-419.18
54	89	696.16	1101.02	-404.86
55	90	660.63	1043.73	-383.10
56	91	608.11	959.22	-351.11
57	92	531.41	835.82	-304.41
58	93	418.87	654.71	-235.84
59	94	251.86	385.85	-133.99

Appendix 2

Sample Nonforfeiture Calculations

Sample Insured: \$ 100,000 30-Year Level Premium Policy Issued to a 35 Year-Old Male Standard Non-Nicotine User risk
Values shown are per \$ 1,000 of Death Benefit.

Minimum Cash Value under Standard Nonforfeiture Law Unitary Method

1. Net Level Premium

$$P_{35} \left(\overline{A}_{35:\overline{60}|}^1 \right) = \frac{\overline{M}_{35} - \overline{M}_{95}}{\frac{D_{35}}{N_{35} - N_{95}}} = \frac{204.58029}{20.68443} = 9.89054$$

2. Expense Allowance

$$\begin{aligned} EA_{35} &= 0.01 * AAI + 1.25 * \min \left(P_{35} \left(\overline{A}_{35:\overline{60}|}^1 \right), 0.04 * AAI \right) \\ &= 0.01 * 1000 + 1.25 * \min (9.89054, 0.04 * 1000) = 22.36318 \end{aligned}$$

3. Adjusted Premium

$$r = \frac{\overline{A}_{35:\overline{60}|}^1 + EA_{35}}{\frac{\sum_{t=0}^{95-x} (GP_{[35]+3} * D_{[35]+3})}{D_{35}}} = \frac{204.58029 + 22.36318}{304.74113} = 0.74471$$

$$P_{[35]+3}^A = r * GP_{[35]+3} = 0.74471 * 3.23 = 2.40541$$

4. Nonforfeiture Cash Values

$$\begin{aligned} {}_3SNFLCV_{35} &= \left(\frac{\overline{M}_{38} - \overline{M}_{95}}{D_{38}} \right) - \frac{\sum_{38}^{56} (r * GP_{[35]+3} * D_{38})}{D_{38}} \\ &= \left(\frac{204.58029}{0.88586} \right) - \frac{220.00891}{0.88586} = 220.17698 - 248.35577 = -21.16652 \end{aligned}$$

Minimum Nonforfeiture Cash Value

$${}_3NFCV_{35} = -21.16652$$

$${}_3NFCV_{35} = \max(-21.16652, 0)$$

$${}_3NFCV_{35} = 0.00$$

Appendix 3

Numerical Demonstration Current Scale Gross Premiums

\$ 100,000 30-Year Level Premium Policy Issued to a 35 Year-Old Male Standard Non-Nicotine User risk

t	Gross Premium Per \$1000 w/o Policy Fee	t	Gross Premium Per \$1000 w/o Policy Fee
0	3.23	30	21.21
1	3.23	31	23.23
2	3.23	32	25.33
3	3.23	33	27.56
4	3.23	34	30.06
5	3.23	35	32.97
6	3.23	36	36.52
7	3.23	37	40.66
8	3.23	38	45.02
9	3.23	39	49.70
10	3.23	40	55.96
11	3.23	41	65.53
12	3.23	42	81.00
13	3.23	43	102.38
14	3.23	44	127.67
15	3.23	45	149.56
16	3.23	46	166.48
17	3.23	47	184.42
18	3.23	48	204.03
19	3.23	49	225.85
20	3.23	50	250.13
21	3.23	51	276.82
22	3.23	52	305.69
23	3.23	53	336.38
24	3.23	54	368.58
25	3.23	55	400.49
26	3.23	56	432.07
27	3.23	57	465.20
28	3.23	58	500.16
29	3.23	59	518.12

Statements of Variability

Direct Response Application

10582-AR

Variable fields are as follow. Any state/entity specific deviations or exceptions are included.

Company Address – The application provides an address (Street and/or P O Box, City, State, and ZIP Code) for the company to which the completed application may be mailed. The address for the company is filed as variable material to allow for updates. The address provided will coincide with the appropriate receiving department. Potential alternatives, if any, will need to be provided.
i.e. San Antonio; League City

Amount – Based on the product solicited, the three most popular applied for face amounts (based on experience) will be pre-filled as possible selections. A reasonable range for the displayed amounts would be a minimum of \$25,000 and a maximum of \$250,000. The applicant is able to choose an amount other than those shown on the application by selecting the “Other” box and filling in the desired dollar amount.

Automatic Premium Loan Provision Requested – The check box to elect the Automatic Premium Loan Provision (“APL”) is only applicable to Whole Life products. When the product solicited is a Term product or a Whole Life product that does not offer APL, the “No” check box will be pre-filled. When the product solicited is a Whole Life product that offers APL, both check boxes will be open, allowing the applicant to choose.

Payment Selection – This section will be pre-filled with payment options that vary based on the market. For markets where an inherent payment vehicle is available (relationships with banks, credit card issuers, mortgages, etc...), such financial institution may have preferred language that we are required to use. However, all language will involve the authorization of premium payments to be automatically charged/deducted from the prospective insureds account.

Examples of the basic types of text that will appear are as follows:

For broad market solicitations:

1. ☐ Automatic monthly deductions from my checking or savings account.
(Enclose a voided check or a deposit slip for the account to be charged.)
2. ☐ Charge monthly premiums to my: ☐ Visa ☐ MasterCard ☐ Discover
□□□□□□□□□□□□□□□□ □□/□□
(Account Number) (Exp. Date)
3. Bill me/us. (Send no money now.)

For bank solicitations: I understand that by signing this application I authorize my premiums to be automatically deducted from my [name of bank] account once the policy is issued. All premiums for this coverage will be automatically deducted monthly from my account until I instruct otherwise.

I understand that by signing this application I authorize my premium payments to be automatically charged to my [name of bank] checking account once the policy is issued. All premium payments for this coverage will be automatically charged monthly to my checking account until I instruct otherwise.

I understand that by signing this application I authorize my premium payments to be automatically debited from my [name of bank] checking account once the policy issued. All premium payments for this coverage will be debited monthly from my [name of bank] checking account until I instruct otherwise.

For credit card solicitations: I understand that by signing this application I authorize my premiums to be automatically charged to my (name of bank) account once the policy is issued. All premiums for this coverage will be automatically charged monthly to my account, subject to credit approval, until I instruct otherwise.

I understand that by signing this application I authorize my premium payments to be automatically charged to my (name of bank) credit card account once the policy is issued. All premium payments for this coverage will be automatically charged monthly to my credit card account until I instruct otherwise.

I understand that by signing this application I authorize my premium payments to be automatically debited from my [name of bank] credit card account once the policy is issued. All premium payments for this coverage will be debited monthly from my [name of bank] credit card account until I instruct otherwise.

For Mortgage Solicitations: I understand that by signing this application I hereby certify that I have the authority and do so authorize (name of Mortgage Lender) to add my life insurance premium payments to my mortgage payment.

I understand that by signing this application I hereby certify that I have the authority and do so authorize (name of Mortgage Lender) to add my life insurance premium payments to my mortgage payment.

I understand that by signing this application I authorize (name of Mortgage Lender) to bill and collect premium with my mortgage payment.

The above does not represent every possible scenario but serves as examples.

For solicitations where a billing mechanism is not inherent in the marketing, the following options or some combination of the options would be provided:

1. Automatic monthly deductions from my checking or savings account. (Enclose a number deposit slip or voided check.)
2. Charge monthly premiums to my: (checkboxes for each) Visa, MasterCard, Discover (and fields for credit card number and expiration date).
3. Bill me. (Send no money now.)
4. Check Enclosed for my first premium
5. Payment attached for my first premium

CONSUMER DISCLOSURE STATEMENT – Within the Agreements section, the last statement: “I have read the Consumer Disclosure on the Sale of Insurance accompanying this application.” will only appear for those applications produced for the Bank Solicitation channel. The Consumer Disclosure on the Sale of Insurance is contained on the accompanying letter that is provided with the application when the product is solicited via banks and states the following:

-Not Insured by FDIC

-Not a Deposit of or Guaranteed by (Bank Name) or any Federal Government Agency or any (Bank Name) Affiliates.

“I have received and read the Summary and Disclosure Notice for Accelerated Benefits”. – This statement will only appear when the product being applied for is the Term product in this filing. The application will also be used for a whole life product in which Accelerated Benefit Riders will not be applicable.

We certify that any change or modification to a variable item will be administered in accordance with the requirements in the Variability of Information section from the applicable product standards, including any requirements for prior approval of a change or modification.

CERTIFICATION OF COMPLIANCE

The Company has reviewed the captioned form(s) below, and certifies that to the best of its knowledge and belief, the form(s) submitted is (are) in compliance with the following:

Rule & Regulation 19
Rule & Regulation 49
ACA 23-79-138 and Bulletin 15-2009
ACA 23-80-206 (Flesch Certification, minimum of 40)

<u>Form</u>	<u>Form Name</u>	<u>Scoring(s)</u>
10582-AR	Application for Individual Life Insurance	50.2



Rex D. Hemme
Senior Vice President & Actuary
American National Insurance Company



Tobie Brink, Life Policy Analyst III
Product Development – Actuarial
Home Office : One Moody Plaza, 14th Floor
Galveston, Texas 77550

e-mail: tobie.brink@ANICO.com
Phone: (409) 763-4661 x 4265
Fax: (409) 766-6522

January 2, 2013

Arkansas Insurance Department
Compliance - Life and Health
1200 West Third Street
Little Rock AR 72201-1904

RE: American National Insurance Company (NAIC: 60739 FEIN: 74-0484030) Filing Of:
Direct Marketing Term Life
SERFF Tracking Number AMNA-128680393
Company Tracking Number: ART12-DM

Dear Reviewer:

Form ART12(10), Form ART12-DP10, Form ART12-DP20, and Form ART12-DP30 were approved on 5/9/2012 under SERFF Tracking Number AMNA-128230158. Please find samples of each of these data pages under the supporting documentation tab to be used by our direct marketing channel to include direct mail, internet sales, and endorsed market. The minimum face amount is \$25,000.

Application 10582-AR will be used to apply for this product. This application replaces 10498-AR approved on 2/9/2012 under SERFF Tracking Number AMNA-127992033. The only changes made to the application was the removal of Apt. # and the addition of the statement **“I have received and read the Summary and Disclosure Notice for Accelerated Benefits.”**

This application will also be used to apply for Form NPWL09DM(10) approved on 2/17/2010 under SERFF Tracking Number AMNA-126484400.

The following riders can be applied for:

- Children’s Term Rider, Form CTR09DM, approved on 3/2/2010 under SERFF Tracking Number AMNA-126513629.
- Aviation Exclusion Rider, 1048XR, approved on 6/29/1982.
- Accelerated Benefit Rider – Terminal Illness, Form ABR11-TM, approved on 5/9/2011 under SERFF Tracking Number AMNA-127076498.

Accelerated Benefit Rider Forms – Supporting Documentation

- **DMABR** is the Summary and Disclosure Notice. This form will be provided at the time of application. The form must be returned to the Company with the completed application. The form provides various information regarding the benefit available, possible tax consequences, possible affect on receipt of public funds and other important information.
- **Form ABR12DMEF(10)** is the Accelerated Benefit Election Form that will be sent to the insured after reporting a qualifying condition and will include the offer to accelerate benefits. The form must be signed and returned to effectuate the acceleration. The form demonstrates the effect the acceleration of the death benefit(s) has on the policy and/or covered riders.
- **DABRE** is the Summary and Disclosure Notice provided to the Owner with the Accelerated Benefit Election Form. The form provides various information regarding the benefit available, possible tax consequences, possible affect on receipt of public funds and other important information. This form is sent with the Accelerated Benefit Election Form and requires that the Owner signs the form and return it with the Accelerated Benefit Election Form.

In order for a policy to be eligible for the terminal illness rider, there must be a minimum \$25,000 total death benefit. The accelerated death benefit rider will not be available on total death benefits exceeding \$1,000,000; this includes any previously issued policies with accelerated benefits.

This rider will be added at the time of application for new issues and available post issue for currently in-force business. This rider will be attached to and made part of the policy. There is no additional premium associated with these riders. An administrative fee, not to exceed \$500, will be deducted upon acceleration.

Additional information/supporting documentation included in this submission is as follows:

- Actuarial Memorandum for each plan
- Statement of Variability
- Readability Certification
- Sample policy summary
- As the above listed products are issued on a sex-distinct basis, we confirm that the policy will not be issued in any employer-employee plans that are subject to the Norris decision and/or Title VII of the Civil Rights Act of 1964.
- Payment of the required filing fees have been submitted via EFT.
- Any requirement for a third party authorization has been bypassed, as this is not a third-party filing.

Sincerely,

Tobie Brink

Tobie Brink
Life Policy Analyst III



Policy Number: 12345678
Page 1 of 2

STATEMENT OF POLICY COST AND BENEFIT INFORMATION

American National Insurance Company
One Moody Plaza, Galveston, TX 77550
Telephone: (409) 763-1112

Insured: JOHN DOE
Issue Age: 35 Sex: MALE

Date Prepared: 11/1/2012

"Age" means age nearest birthday

Guaranteed Initial Annual Premium(1)	Years Payable
Plan of Insurance: INDIVIDUAL TERM LIFE INSURANCE TO AGE [95]	[60]

Level Premium Period: [10] Years

Additional Benefit(s):

[Additional Benefit Name]

Attained Age	Death Benefit	Guaranteed Annual Premium(1)
35	\$ 100,000	\$ 246.00
36	\$ 100,000	\$ 246.00
37	\$ 100,000	\$ 246.00
38	\$ 100,000	\$ 246.00
39	\$ 100,000	\$ 246.00
45	\$ 100,000	\$ 427.00
55	\$ 100,000	\$ 833.00
65	\$ 100,000	\$ 2,181.00

Attained Age is the Insured's Issue Age plus the number of Policy Years completed.

Cost Comparison Disclosure

Indexes Per \$1000	Base Policy	
	10 YR	20 YR
Surrender Cost Index	2.46	2.92
Net Payment Cost Index	2.46	2.92

These indexes are useful only for comparison of the relative costs of two or more similar policies. An explanation of the intended use of these Indexes is provided in the Life Insurance buyer's Guide.



Policy Number: 12345678
Page 1 of 2

FOOTNOTES

- (1) Premiums shown are on an annual basis. For the actual premiums, if on any other basis, refer to your policy.

This policy summary is a brief description of the highlights of the plan. This is a policy summary only, and is not a contract. See your policy for exact terms and conditions.

If you have any questions concerning this statement, you may contact us at:

American National Insurance Company
One Moody Plaza
Galveston TX 77550
(409) 763-4661

DATA PAGE				
POLICY NUMBER	[12345678]	[MAY 1, 2012]	ISSUE DATE	
OWNER	[JOHN DOE]	[\$100,000]	FACE AMOUNT	
INSURED				
INSURED NAME	[JOHN DOE]	[35]	ISSUE AGE "Age" means age [last] birthday	
CLASS	[STANDARD NICOTINE NON-USER]	[MALE]	SEX	
PREMIUMS AND RIDERS				
BENEFIT DESCRIPTION		INITIAL ANNUAL PREMIUM	YEARS PAYABLE	
INDIVIDUAL TERM LIFE INSURANCE TO AGE [95]		[\$ 246.00]	[60]	
Form	[Form ART12(10)]			
Level Premium Period	[10] Years			
Term Expiry Date	[MAY 1, 2072]			
[NAME OF A RIDER]		[Rider Prem]	[]	
Form	[Rider Form Number]			
TOTAL INITIAL ANNUAL PREMIUM		[\$ 246.00]		
INITIAL PREMIUM BY PAYMENT MODE				
INCLUDES PREMIUMS FOR [Form ART12(10)] AND ANY RIDERS AND ANNUAL POLICY FEE OF \$[60.00]				
YOUR INITIAL PREMIUM MODE IS: [ANNUAL]				
ANNUAL	SEMI-ANNUAL	QUARTERLY	[MONTHLY]	SPECIAL MONTHLY
[\$ 246.00]	[\$ 123.00]	[\$ 62.00]	[\$ 22.00]	[\$ 20.00]
BASIS OF VALUES FOR SETTLEMENT OPTIONS				
[The minimum guaranteed settlement rates are based on 1.5% interest and the Annuity 2000 mortality table. The age at settlement is the annuitant's age last birthday adjusted downward by one year for each full five year period that has elapsed since January 1, 2000.]				
Upon Your request, We will provide You the settlement option tables.				

DATA PAGE CONTINUED

POLICY NUMBER	[12345678]	INSURED	[JOHN DOE]	[MALE]	[35]
---------------	------------	---------	------------	--------	------

CONVERSION SCHEDULE

Conversion Expiry Date:	[May 31, 2017]
Conversion Credit Expiry Date:	[May 1, 2017]

DATA PAGE CONTINUED

POLICY NUMBER	[12345678]	INSURED	[JOHN DOE]	[MALE]	[35]
---------------	------------	---------	------------	--------	------

GUARANTEED MAXIMUM ANNUAL PREMIUMS

ATTAINED AGE	ANNUAL PREMIUM	RIDER(S)	TOTAL ANNUAL PREMIUM	TOTAL PREMIUM BY CURRENT PREMIUM MODE
[35	[\$ 246.00	[\$0.00	[\$ 246.00	[\$ 246.00
36	\$ 246.00	\$0.00	\$ 246.00	\$ 246.00
37	\$ 246.00	\$0.00	\$ 246.00	\$ 246.00
38	\$ 246.00	\$0.00	\$ 246.00	\$ 246.00
39	\$ 246.00	\$0.00	\$ 246.00	\$ 246.00
40	\$ 246.00	\$0.00	\$ 246.00	\$ 246.00
41	\$ 246.00	\$0.00	\$ 246.00	\$ 246.00
42	\$ 246.00	\$0.00	\$ 246.00	\$ 246.00
43	\$ 246.00	\$0.00	\$ 246.00	\$ 246.00
44	\$ 246.00	\$0.00	\$ 246.00	\$ 246.00
45	\$ 792.00	\$0.00	\$ 792.00	\$ 792.00
46	\$ 861.00	\$0.00	\$ 861.00	\$ 861.00
47	\$ 918.00	\$0.00	\$ 918.00	\$ 918.00
48	\$ 963.00	\$0.00	\$ 963.00	\$ 963.00
49	\$ 1,020.00	\$0.00	\$ 1,020.00	\$ 1,020.00
50	\$ 1,095.00	\$0.00	\$ 1,095.00	\$ 1,095.00
51	\$ 1,191.00	\$0.00	\$ 1,191.00	\$ 1,191.00
52	\$ 1,308.00	\$0.00	\$ 1,308.00	\$ 1,308.00
53	\$ 1,443.00	\$0.00	\$ 1,443.00	\$ 1,443.00
54	\$ 1,614.00	\$0.00	\$ 1,614.00	\$ 1,614.00
55	\$ 1,806.00	\$0.00	\$ 1,806.00	\$ 1,806.00
56	\$ 2,004.00	\$0.00	\$ 2,004.00	\$ 2,004.00
57	\$ 2,196.00	\$0.00	\$ 2,196.00	\$ 2,196.00
58	\$ 2,388.00	\$0.00	\$ 2,388.00	\$ 2,388.00
59	\$ 2,613.00	\$0.00	\$ 2,613.00	\$ 2,613.00
60	\$ 2,886.00	\$0.00	\$ 2,886.00	\$ 2,886.00
61	\$ 3,219.00	\$0.00	\$ 3,219.00	\$ 3,219.00
62	\$ 3,606.00	\$0.00	\$ 3,606.00	\$ 3,606.00
63	\$ 4,029.00	\$0.00	\$ 4,029.00	\$ 4,029.00
64	\$ 4,470.00	\$0.00	\$ 4,470.00	\$ 4,470.00
65	\$ 4,929.00	\$0.00	\$ 4,929.00	\$ 4,929.00
66	\$ 5,394.00	\$0.00	\$ 5,394.00	\$ 5,394.00
67	\$ 5,880.00	\$0.00	\$ 5,880.00	\$ 5,880.00
68	\$ 6,393.00	\$0.00	\$ 6,393.00	\$ 6,393.00
69	\$ 6,969.00	\$0.00	\$ 6,969.00	\$ 6,969.00
70	\$ 7,641.00	\$0.00	\$ 7,641.00	\$ 7,641.00
71	\$ 8,457.00	\$0.00	\$ 8,457.00	\$ 8,457.00
72	\$ 9,411.00	\$0.00	\$ 9,411.00	\$ 9,411.00
73	\$ 10,416.00	\$0.00	\$ 10,416.00	\$ 10,416.00
74	\$ 11,496.00	\$0.00	\$ 11,496.00	\$ 11,496.00

DATA PAGE CONTINUED

POLICY NUMBER	[12345678]	INSURED	[JOHN DOE]	[MALE]	[35]
---------------	------------	---------	------------	--------	------

GUARANTEED MAXIMUM ANNUAL PREMIUMS

ATTAINED AGE	ANNUAL PREMIUM	RIDER(S)	TOTAL ANNUAL PREMIUM	TOTAL PREMIUM BY CURRENT PREMIUM MODE
75	\$ 12,672.00	\$0.00	\$ 12,672.00	\$ 12,672.00
76	\$ 13,998.00	\$0.00	\$ 13,998.00	\$ 13,998.00
77	\$ 15,540.00	\$0.00	\$ 15,540.00	\$ 15,540.00
78	\$ 17,331.00	\$0.00	\$ 17,331.00	\$ 17,331.00
79	\$ 19,338.00	\$0.00	\$ 19,338.00	\$ 19,338.00
80	\$ 21,576.00	\$0.00	\$ 21,576.00	\$ 21,576.00
81	\$ 24,009.00	\$0.00	\$ 24,009.00	\$ 24,009.00
82	\$ 26,586.00	\$0.00	\$ 26,586.00	\$ 26,586.00
83	\$ 29,400.00	\$0.00	\$ 29,400.00	\$ 29,400.00
84	\$ 32,529.00	\$0.00	\$ 32,529.00	\$ 32,529.00
85	\$ 36,009.00	\$0.00	\$ 36,009.00	\$ 36,009.00
86	\$ 39,837.00	\$0.00	\$ 39,837.00	\$ 39,837.00
87	\$ 43,974.00	\$0.00	\$ 43,974.00	\$ 43,974.00
88	\$ 48,372.00	\$0.00	\$ 48,372.00	\$ 48,372.00
89	\$ 52,986.00	\$0.00	\$ 52,986.00	\$ 52,986.00
90	\$ 57,582.00	\$0.00	\$ 57,582.00	\$ 57,582.00
91	\$ 62,106.00	\$0.00	\$ 62,106.00	\$ 62,106.00
92	\$ 66,846.00	\$0.00	\$ 66,846.00	\$ 66,846.00
93	\$ 71,844.00	\$0.00	\$ 71,844.00	\$ 71,844.00
94]	\$ 77,109.00]	\$ 0.00]	\$ 77,109.00]	\$ 77,109.00]

DATA PAGE				
POLICY NUMBER	[12345678]	[MAY 1, 2012]	ISSUE DATE	
OWNER	[JOHN DOE]	[\$100,000]	FACE AMOUNT	
INSURED				
INSURED NAME	[JOHN DOE]	[35]	ISSUE AGE "Age" means age [last] birthday	
CLASS	[STANDARD NICOTINE NON-USER]	[MALE]	SEX	
PREMIUMS AND RIDERS				
BENEFIT DESCRIPTION		INITIAL ANNUAL PREMIUM	YEARS PAYABLE	
INDIVIDUAL TERM LIFE INSURANCE TO AGE [95]		[\$ 302.00]	[60]	
Form	[Form ART12(10)]			
Level Premium Period	[20] Years			
Term Expiry Date	[MAY 1, 2072]			
[NAME OF A RIDER]		[Rider Prem]	[]	
Form	[Rider Form Number]			
TOTAL INITIAL ANNUAL PREMIUM		[\$ 302.00]		
INITIAL PREMIUM BY PAYMENT MODE				
INCLUDES PREMIUMS FOR [Form ART12(10)] AND ANY RIDERS AND ANNUAL POLICY FEE OF \$[60.00]				
YOUR INITIAL PREMIUM MODE IS: [ANNUAL]				
ANNUAL	SEMI-ANNUAL	QUARTERLY	[MONTHLY]	SPECIAL MONTHLY
[\$ 302.00]	[\$ 151.00]	[\$ 76.00]	[\$ 27.00]	[\$ 25.00]
BASIS OF VALUES FOR SETTLEMENT OPTIONS				
[The minimum guaranteed settlement rates are based on 1.5% interest and the Annuity 2000 mortality table. The age at settlement is the annuitant's age last birthday adjusted downward by one year for each full five year period that has elapsed since January 1, 2000.]				
Upon Your request, We will provide You the settlement option tables.				

DATA PAGE CONTINUED

POLICY NUMBER	[12345678]	INSURED	[JOHN DOE]	[MALE]	[35]
---------------	------------	---------	------------	--------	------

CONVERSION SCHEDULE

Conversion Expiry Date:	[May 31, 2017]
Conversion Credit Expiry Date:	[May 1, 2017]

DATA PAGE CONTINUED

POLICY NUMBER	[12345678]	INSURED	[JOHN DOE]	[MALE]	[35]
---------------	------------	---------	------------	--------	------

GUARANTEED MAXIMUM ANNUAL PREMIUMS

ATTAINED AGE	ANNUAL PREMIUM	RIDER(S)	TOTAL ANNUAL PREMIUM	TOTAL PREMIUM BY CURRENT PREMIUM MODE
[35]	[\$ 302.00	[\$0.00	[\$ 302.00	[\$ 302.00
36	\$ 302.00	\$0.00	\$ 302.00	\$ 302.00
37	\$ 302.00	\$0.00	\$ 302.00	\$ 302.00
38	\$ 302.00	\$0.00	\$ 302.00	\$ 302.00
39	\$ 302.00	\$0.00	\$ 302.00	\$ 302.00
40	\$ 302.00	\$0.00	\$ 302.00	\$ 302.00
41	\$ 302.00	\$0.00	\$ 302.00	\$ 302.00
42	\$ 302.00	\$0.00	\$ 302.00	\$ 302.00
43	\$ 302.00	\$0.00	\$ 302.00	\$ 302.00
44	\$ 302.00	\$0.00	\$ 302.00	\$ 302.00
45	\$ 302.00	\$0.00	\$ 302.00	\$ 302.00
46	\$ 302.00	\$0.00	\$ 302.00	\$ 302.00
47	\$ 302.00	\$0.00	\$ 302.00	\$ 302.00
48	\$ 302.00	\$0.00	\$ 302.00	\$ 302.00
49	\$ 302.00	\$0.00	\$ 302.00	\$ 302.00
50	\$ 302.00	\$0.00	\$ 302.00	\$ 302.00
51	\$ 302.00	\$0.00	\$ 302.00	\$ 302.00
52	\$ 302.00	\$0.00	\$ 302.00	\$ 302.00
53	\$ 302.00	\$0.00	\$ 302.00	\$ 302.00
54	\$ 302.00	\$0.00	\$ 302.00	\$ 302.00
55	\$ 1,806.00	\$0.00	\$ 1,806.00	\$ 1,806.00
56	\$ 2,004.00	\$0.00	\$ 2,004.00	\$ 2,004.00
57	\$ 2,196.00	\$0.00	\$ 2,196.00	\$ 2,196.00
58	\$ 2,388.00	\$0.00	\$ 2,388.00	\$ 2,388.00
59	\$ 2,613.00	\$0.00	\$ 2,613.00	\$ 2,613.00
60	\$ 2,886.00	\$0.00	\$ 2,886.00	\$ 2,886.00
61	\$ 3,219.00	\$0.00	\$ 3,219.00	\$ 3,219.00
62	\$ 3,606.00	\$0.00	\$ 3,606.00	\$ 3,606.00
63	\$ 4,029.00	\$0.00	\$ 4,029.00	\$ 4,029.00
64	\$ 4,470.00	\$0.00	\$ 4,470.00	\$ 4,470.00
65	\$ 4,929.00	\$0.00	\$ 4,929.00	\$ 4,929.00
66	\$ 5,394.00	\$0.00	\$ 5,394.00	\$ 5,394.00
67	\$ 5,880.00	\$0.00	\$ 5,880.00	\$ 5,880.00
68	\$ 6,393.00	\$0.00	\$ 6,393.00	\$ 6,393.00
69	\$ 6,969.00	\$0.00	\$ 6,969.00	\$ 6,969.00
70	\$ 7,641.00	\$0.00	\$ 7,641.00	\$ 7,641.00
71	\$ 8,457.00	\$0.00	\$ 8,457.00	\$ 8,457.00
72	\$ 9,411.00	\$0.00	\$ 9,411.00	\$ 9,411.00
73	\$ 10,416.00	\$0.00	\$ 10,416.00	\$ 10,416.00
74	\$ 11,496.00	\$0.00	\$ 11,496.00	\$ 11,496.00

DATA PAGE CONTINUED

POLICY NUMBER	[12345678]	INSURED	[JOHN DOE]	[MALE]	[35]
---------------	------------	---------	------------	--------	------

GUARANTEED MAXIMUM ANNUAL PREMIUMS

ATTAINED AGE	ANNUAL PREMIUM	RIDER(S)	TOTAL ANNUAL PREMIUM	TOTAL PREMIUM BY CURRENT PREMIUM MODE
75	\$ 12,672.00	\$0.00	\$ 12,672.00	\$ 12,672.00
76	\$ 13,998.00	\$0.00	\$ 13,998.00	\$ 13,998.00
77	\$ 15,540.00	\$0.00	\$ 15,540.00	\$ 15,540.00
78	\$ 17,331.00	\$0.00	\$ 17,331.00	\$ 17,331.00
79	\$ 19,338.00	\$0.00	\$ 19,338.00	\$ 19,338.00
80	\$ 21,576.00	\$0.00	\$ 21,576.00	\$ 21,576.00
81	\$ 24,009.00	\$0.00	\$ 24,009.00	\$ 24,009.00
82	\$ 26,586.00	\$0.00	\$ 26,586.00	\$ 26,586.00
83	\$ 29,400.00	\$0.00	\$ 29,400.00	\$ 29,400.00
84	\$ 32,529.00	\$0.00	\$ 32,529.00	\$ 32,529.00
85	\$ 36,009.00	\$0.00	\$ 36,009.00	\$ 36,009.00
86	\$ 39,837.00	\$0.00	\$ 39,837.00	\$ 39,837.00
87	\$ 43,974.00	\$0.00	\$ 43,974.00	\$ 43,974.00
88	\$ 48,372.00	\$0.00	\$ 48,372.00	\$ 48,372.00
89	\$ 52,986.00	\$0.00	\$ 52,986.00	\$ 52,986.00
90	\$ 57,582.00	\$0.00	\$ 57,582.00	\$ 57,582.00
91	\$ 62,106.00	\$0.00	\$ 62,106.00	\$ 62,106.00
92	\$ 66,846.00	\$0.00	\$ 66,846.00	\$ 66,846.00
93	\$ 71,844.00	\$0.00	\$ 71,844.00	\$ 71,844.00
94]	\$ 77,109.00]	\$ 0.00]	\$ 77,109.00]	\$ 77,109.00]

DATA PAGE				
POLICY NUMBER	[12345678]	[MAY 1, 2012]	ISSUE DATE	
OWNER	[JOHN DOE]	[\$100,000]	FACE AMOUNT	
INSURED				
INSURED NAME	[JOHN DOE]	[35]	ISSUE AGE "Age" means age [last] birthday	
CLASS	[STANDARD NICOTINE NON-USER]	[MALE]	SEX	
PREMIUMS AND RIDERS				
BENEFIT DESCRIPTION		INITIAL ANNUAL PREMIUM	YEARS PAYABLE	
INDIVIDUAL TERM LIFE INSURANCE TO AGE [95]		[\$ 383.00]	[60]	
Form	[Form ART12(10)]			
Level Premium Period	[30] Years			
Term Expiry Date	[MAY 1, 2072]			
[NAME OF A RIDER]		[Rider Prem]	[]	
Form	[Rider Form Number]			
TOTAL INITIAL ANNUAL PREMIUM		[\$ 383.00]		
INITIAL PREMIUM BY PAYMENT MODE				
INCLUDES PREMIUMS FOR [Form ART12(10)] AND ANY RIDERS AND ANNUAL POLICY FEE OF \$[60.00]				
YOUR INITIAL PREMIUM MODE IS: [ANNUAL]				
ANNUAL	SEMI-ANNUAL	QUARTERLY	[MONTHLY]	SPECIAL MONTHLY
[\$ 383.00]	[\$ 192.00]	[\$ 96.00]	[\$ 34.00]	[\$ 32.00]
BASIS OF VALUES FOR SETTLEMENT OPTIONS				
[The minimum guaranteed settlement rates are based on 1.5% interest and the Annuity 2000 mortality table. The age at settlement is the annuitant's age last birthday adjusted downward by one year for each full five year period that has elapsed since January 1, 2000.]				
Upon Your request, We will provide You the settlement option tables.				

DATA PAGE CONTINUED

POLICY NUMBER	[12345678]	INSURED	[JOHN DOE]	[MALE]	[35]
---------------	------------	---------	------------	--------	------

CONVERSION SCHEDULE

Conversion Expiry Date:	[May 31, 2017]
Conversion Credit Expiry Date:	[May 1, 2017]

DATA PAGE CONTINUED

POLICY NUMBER	[12345678]	INSURED	[JOHN DOE]	[MALE]	[35]
---------------	------------	---------	------------	--------	------

GUARANTEED MAXIMUM ANNUAL PREMIUMS

ATTAINED AGE	ANNUAL PREMIUM	RIDER(S)	TOTAL ANNUAL PREMIUM	TOTAL PREMIUM BY CURRENT PREMIUM MODE
[35	[\$ 383.00	[\$0.00	[\$ 383.00	[\$ 383.00
36	\$ 383.00	\$0.00	\$ 383.00	\$ 383.00
37	\$ 383.00	\$0.00	\$ 383.00	\$ 383.00
38	\$ 383.00	\$0.00	\$ 383.00	\$ 383.00
39	\$ 383.00	\$0.00	\$ 383.00	\$ 383.00
40	\$ 383.00	\$0.00	\$ 383.00	\$ 383.00
41	\$ 383.00	\$0.00	\$ 383.00	\$ 383.00
42	\$ 383.00	\$0.00	\$ 383.00	\$ 383.00
43	\$ 383.00	\$0.00	\$ 383.00	\$ 383.00
44	\$ 383.00	\$0.00	\$ 383.00	\$ 383.00
45	\$ 383.00	\$0.00	\$ 383.00	\$ 383.00
46	\$ 383.00	\$0.00	\$ 383.00	\$ 383.00
47	\$ 383.00	\$0.00	\$ 383.00	\$ 383.00
48	\$ 383.00	\$0.00	\$ 383.00	\$ 383.00
49	\$ 383.00	\$0.00	\$ 383.00	\$ 383.00
50	\$ 383.00	\$0.00	\$ 383.00	\$ 383.00
51	\$ 383.00	\$0.00	\$ 383.00	\$ 383.00
52	\$ 383.00	\$0.00	\$ 383.00	\$ 383.00
53	\$ 383.00	\$0.00	\$ 383.00	\$ 383.00
54	\$ 383.00	\$0.00	\$ 383.00	\$ 383.00
55	\$ 383.00	\$0.00	\$ 383.00	\$ 383.00
56	\$ 383.00	\$0.00	\$ 383.00	\$ 383.00
57	\$ 383.00	\$0.00	\$ 383.00	\$ 383.00
58	\$ 383.00	\$0.00	\$ 383.00	\$ 383.00
59	\$ 383.00	\$0.00	\$ 383.00	\$ 383.00
60	\$ 383.00	\$0.00	\$ 383.00	\$ 383.00
61	\$ 383.00	\$0.00	\$ 383.00	\$ 383.00
62	\$ 383.00	\$0.00	\$ 383.00	\$ 383.00
63	\$ 383.00	\$0.00	\$ 383.00	\$ 383.00
64	\$ 383.00	\$0.00	\$ 383.00	\$ 383.00
65	\$ 4,929.00	\$0.00	\$ 4,929.00	\$ 4,929.00
66	\$ 5,394.00	\$0.00	\$ 5,394.00	\$ 5,394.00
67	\$ 5,880.00	\$0.00	\$ 5,880.00	\$ 5,880.00
68	\$ 6,393.00	\$0.00	\$ 6,393.00	\$ 6,393.00
69	\$ 6,969.00	\$0.00	\$ 6,969.00	\$ 6,969.00
70	\$ 7,641.00	\$0.00	\$ 7,641.00	\$ 7,641.00
71	\$ 8,457.00	\$0.00	\$ 8,457.00	\$ 8,457.00
72	\$ 9,411.00	\$0.00	\$ 9,411.00	\$ 9,411.00
73	\$ 10,416.00	\$0.00	\$ 10,416.00	\$ 10,416.00
74	\$ 11,496.00	\$0.00	\$ 11,496.00	\$ 11,496.00

DATA PAGE CONTINUED

POLICY NUMBER	[12345678]	INSURED	[JOHN DOE]	[MALE]	[35]
---------------	------------	---------	------------	--------	------

GUARANTEED MAXIMUM ANNUAL PREMIUMS

ATTAINED AGE	ANNUAL PREMIUM	RIDER(S)	TOTAL ANNUAL PREMIUM	TOTAL PREMIUM BY CURRENT PREMIUM MODE
75	\$ 12,672.00	\$0.00	\$ 12,672.00	\$ 12,672.00
76	\$ 13,998.00	\$0.00	\$ 13,998.00	\$ 13,998.00
77	\$ 15,540.00	\$0.00	\$ 15,540.00	\$ 15,540.00
78	\$ 17,331.00	\$0.00	\$ 17,331.00	\$ 17,331.00
79	\$ 19,338.00	\$0.00	\$ 19,338.00	\$ 19,338.00
80	\$ 21,576.00	\$0.00	\$ 21,576.00	\$ 21,576.00
81	\$ 24,009.00	\$0.00	\$ 24,009.00	\$ 24,009.00
82	\$ 26,586.00	\$0.00	\$ 26,586.00	\$ 26,586.00
83	\$ 29,400.00	\$0.00	\$ 29,400.00	\$ 29,400.00
84	\$ 32,529.00	\$0.00	\$ 32,529.00	\$ 32,529.00
85	\$ 36,009.00	\$0.00	\$ 36,009.00	\$ 36,009.00
86	\$ 39,837.00	\$0.00	\$ 39,837.00	\$ 39,837.00
87	\$ 43,974.00	\$0.00	\$ 43,974.00	\$ 43,974.00
88	\$ 48,372.00	\$0.00	\$ 48,372.00	\$ 48,372.00
89	\$ 52,986.00	\$0.00	\$ 52,986.00	\$ 52,986.00
90	\$ 57,582.00	\$0.00	\$ 57,582.00	\$ 57,582.00
91	\$ 62,106.00	\$0.00	\$ 62,106.00	\$ 62,106.00
92	\$ 66,846.00	\$0.00	\$ 66,846.00	\$ 66,846.00
93	\$ 71,844.00	\$0.00	\$ 71,844.00	\$ 71,844.00
94]	\$ 77,109.00]	\$ 0.00]	\$ 77,109.00]	\$ 77,109.00]



Accelerated Benefit Election Form

American National Insurance Company
One Moody Plaza, Galveston, TX 77550-7947

page 1 of 3

Policy Numbers: _____

1. RIDER INSURED

Name: Last	First	M.I.
_____	_____	_____
Daytime telephone		
() _____		
Address	City	State ZIP
_____	_____	_____

2. OWNER

Name: Last	First	M.I.
_____	_____	_____
Daytime telephone		
() _____		
Address	City	State ZIP
_____	_____	_____

3. ELIGIBLE DEATH BENEFIT ACCELERATED DUE TO

- ☐ Terminal Illness
- Qualifying Event: _____
- Date of occurrence of Qualifying Event: _____

4. EFFECT ON COVERAGE

Coverages*:	Death Benefit Before Acceleration	Amount Eligible	Death Benefit After Acceleration
_____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____



Premium: (for all coverages)	Before Acceleration	After Acceleration
	\$ _____	\$ _____
Cash Surrender Value	Before Acceleration	After Acceleration
	\$ _____	\$ _____
Policy Debt	Before Acceleration	After Acceleration
	\$ _____	\$ _____

*Upon acceleration, any Rider attached to the Base Policy will be treated as though the Base Policy Insured has died. Any conversion privilege offered under any Rider must be exercised, if desired, at the time of election. Complete and submit the appropriate request for policy change with this election form.

5. ACCELERATED BENEFIT PAYMENT

The Accelerated Benefit Payment is the:

Total Eligible Death Benefit	\$ _____	reduced by:
An Actuarial Discount	\$ _____	reduced by:
An Administrative Charge	\$ _____	reduced by:
Any Policy Debt	\$ _____	equaling.

Total Accelerated Benefit

Payment:

(or cash surrender value, if greater)

\$ _____

☐ Lump Sum

☐ Periodic Payments

Please specify the non-life contingent Settlement Option elected (refer to Your Base Policy for available Settlement Options).

Frequency for Periodic Payments (choose one):

☐ Annual

☐ Semi-Annual

☐ Quarterly

☐ Monthly

FRAUD WARNING

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinement in prison.

IMPORTANT NOTICES

Payment of Accelerated Benefits will eliminate the Death Benefit otherwise payable under the Base Policy or Covered Rider(s). Receipt of Accelerated Benefits may adversely affect the recipient's eligibility for Medicaid or other government benefits or entitlements.

Receipt of Accelerated Benefits may be a taxable event. Please consult your personal tax advisor or attorney to determine the tax status of any benefits paid under this rider.

SIGNATURES

I understand and agree that by signing below:

- I accept the offer for the Accelerated Benefit Payment.
- The coverage(s) will be affected as shown above.
- I will not receive any future death benefit on the coverage(s) accelerated.



- This election for accelerated benefits is voluntary and without coercion on the part of any third party.

Signature of Owner

Date

I, as Assignee and/or Irrevocable Beneficiary of the Policy Numbers specified above, consent to the acceleration of the Eligible Death Benefit as applied for. I understand that the Accelerated Death Benefit Payment will be paid to the Owner and will eliminate the death benefit available upon the death of the Rider Insured.

Signature of Assignee (if applicable)

Date

Signature of Irrevocable Beneficiary (if applicable)

Date



Summary and Disclosure Notice for Accelerated Benefits

Issued by American National Insurance Company
One Moody Plaza, Galveston, TX 77550-7947

page 1 of 1



THIS SUMMARY PROVIDES A BRIEF DESCRIPTION OF THE BASIC FEATURES OF THE ACCELERATED BENEFIT RIDER LISTED BELOW. THIS IS NOT AN INSURANCE CONTRACT, BUT ONLY A SUMMARY OF THE COVERAGE PROVIDED BY THE RIDER.

Payment of an Accelerated Benefit means that Your Base Policy or Covered Rider(s), for which the Accelerated Benefit is paid, will terminate. The death benefit that would have been paid to the Beneficiary after the death of the Rider Insured will be paid to You prior to the death of the Rider Insured. You will not receive the full death benefit, but rather a reduced amount called the Accelerated Benefit Payment.

Receipt of an Accelerated Benefit may be a taxable event. You should consult a tax advisor regarding the tax status of any benefit paid to You under this Rider. Receipt of Accelerated Benefits may affect your eligibility for Medicaid, supplemental security income, or other government benefits or entitlements.

There is no additional premium required for these Riders.

An administrative fee, not to exceed \$500, will be deducted from the Accelerated Benefit Payment.

Accelerated Benefit Rider for Terminal Illness – Covers an illness or chronic condition that is reasonably expected to result in the death of the Rider Insured within 24 months or less.

No Accelerated Benefit will be paid under any Accelerated Benefit Rider for a condition that results from any self-inflicted injury or attempted suicide.

The Accelerated Benefit Payment will be equal to the Eligible Death Benefit less the actuarial discount, as determined by Us; an administrative charge not to exceed \$500; and any policy debt, if the qualifying Rider Insured is also the Base Policy Insured. The Accelerated Benefit Payment for the Base Policy Insured will never be less than the cash surrender value of the Base Policy, if any.

You may choose to receive the Accelerated Benefit Payment in a lump sum or a series of periodic payments. If You elect periodic payments, You may apply the Accelerated Benefit Payment to any non-life contingent Settlement Option pursuant to the Settlement Options provision of the Base Policy.

If an Accelerated Benefit is elected for the Base Policy Insured, any Rider attached to the Base Policy will be treated as if the Base Policy Insured has died. Acceleration of a Covered Rider will be treated as though the Rider Insured has died for the purpose of determining the impact of the acceleration on the Base Policy.

I acknowledge that I have reviewed this Summary and Disclosure Notice and have been provided a copy for my records.

Owner

Date



Summary and Disclosure Notice for Accelerated Benefits

Issued by American National Insurance Company
One Moody Plaza, Galveston, TX 77550-7947

THIS SUMMARY PROVIDES A BRIEF DESCRIPTION OF THE BASIC FEATURES OF THE ACCELERATED BENEFIT RIDERS LISTED BELOW. THIS IS NOT AN INSURANCE CONTRACT, BUT ONLY A SUMMARY OF THE COVERAGE PROVIDED BY EACH RIDER.

Your policy may contain some or all of the Accelerated Benefit Riders described in this summary and disclosure notice. You should check Your policy to determine which, if any, of these riders have been attached to Your policy. Payment of an Accelerated Benefit means that Your Base Policy or Covered Rider(s), for which the Accelerated Benefit is paid, will terminate. The death benefit that would have been paid to the Beneficiary after the death of the Rider Insured will be paid to You prior to the death of the Rider Insured. You will not receive the full death benefit, but rather a reduced amount called the Accelerated Benefit Payment.

Receipt of an Accelerated Benefit may be a taxable event. You should consult a tax advisor regarding the tax status of any benefit paid to You under this Rider. Receipt of Accelerated Benefits may affect your eligibility for Medicaid, supplemental security income, or other government benefits or entitlements.

In order to receive Accelerated Benefits, You must request the payment of an Accelerated Benefit and show proof that the Rider Insured has met the qualifying conditions of one of the Accelerated Benefit Riders, as described below.

There is no additional premium required for these Riders.

An administrative fee, not to exceed \$500, will be deducted from the Accelerated Benefit Payment.

Accelerated Benefit Rider for Terminal Illness – Covers an illness or chronic condition that is reasonably expected to result in the death of the Rider Insured within 24 months or less.

No Accelerated Benefit will be paid under any Accelerated Benefit Rider for a condition that results from any self inflicted injury or attempted suicide.

The Accelerated Benefit Payment will be equal to the Eligible Death Benefit less the actuarial discount, as determined by Us; an administrative charge not to exceed \$500; and any policy debt, if the qualifying Rider Insured is also the Base Policy Insured. The Accelerated Benefit Payment for the Base Policy Insured will never be less than the cash surrender value of the Base Policy, if any.

You may choose to receive the Accelerated Benefit Payment in a lump sum or a series of periodic payments. If You elect periodic payments, You may apply the Accelerated Benefit Payment to any non life contingent Settlement Option pursuant to the Settlement Options provision of the Base Policy.

If an Accelerated Benefit is elected for the Base Policy Insured, any Rider attached to the Base Policy will be treated as if the Base Policy Insured has died. Acceleration of a Covered Rider will be treated as though the Rider Insured has died for the purpose of determining the impact of the acceleration on the Base Policy.

ANICO Direct Processes:

As a Direct Marketing division, we send Direct Marketing solicitations to perspective clients through direct mail and electronic media (Email, Banners, SEO, SEM, Aggregators and Call Centers).

Electronic Media process:

- The primary path for the customer is to click on a link within the appropriate media and to enter ANICO Direct's website where if they make a decision to receive a rate quote they proceed to the customer portal.
- The secondary path for the customer is to call on the phone number that is provided within the email or website. There, they can speak to a live person to discuss their needs and complete the process online with a licensed agent.

Direct Mail process:

- The primary path for the customer is to fill out the application and send it to American National for processing.
- As a secondary path, the customer is provided with a URL within the letter; the URL allows the customer to go to ANICO Direct's website where if they make a decision to receive a rate quote, they proceed to the customer portal.
- An additional secondary path is that the customer is also provided with the call center phone number, where they can speak to a live person to discuss their needs and complete the process online with a licensed agent.

The tools used to complete the process online is either a Call Center portal (completed by our call center agents) or the Customer path (completed by the customer applying for the product).

Call Center portal:

- When a customer calls our call center, we have the ability to help them by taking them through the Path which we refer to as the call center portal. In order to write the business for the customer, the agent must be licensed in that state. Within the portal, there is a validation against the licensing system to validate the licensing.
- The process, where necessary, is tailored for the agent to read the disclosures on the screen as a script, with the customers consent to complete the process on their behalf.
- The process also has embedded recordings, since disclosures can be state specific, the portal uses the insured state to queue the appropriate recording to ensure consistency with the disclosures.
- Once the questions and disclosures are completed, the application is generated in Silanes for an e-signature process. The e-signature process is approved by the customer and recorded for validation with a process called CVR (Continuous Voice Recording). The e-signature process is a secured signature process confirming acknowledgement of the application.
- CVR records the entire conversation through a vendor called Verint. The database is completely secured with read-only access to the data base to pull the recordings for review. In order to easily identify the recording, the agent "tags" the conversation with software called TagIt. The policy number is entered into TagIt to identify the recording.

Customer portal:

- They potential customer enters data into a series of data fields, selects the product they are interested in and are asked a series of medical questions. They are then presented with disclosures to agree to. Their responses to the fields and medical questions are saved to a database that is later used to populate the application for signature.
- Once the questions and disclosures have been completed, the application is generated in Silanes for an e-signature process. The e-signature process is approved and completed by the customer. All policies written through the tools above are sent to the administration system for processing.

Administration:

- Once the case is assigned a policy number and signed, the case is sent to the Administration system that will process the application. The final disposition of the case is determined and correspondence is sent from that system. The final correspondence will either be a bill and policy or a decline letter.



877.698.0987

Live Support
ONLINE[ABOUT US](#) | [FAQS](#) | [PRIVACY](#) | [CONTACT US](#)**1** GET A QUOTE & CHOOSE COVERAGE**2** APPLY FOR INSTANT COVERAGE**3** PAYMENT OPTIONS**STEP-2: Apply For Instant Coverage**

All asterisked * fields must be completed.

You are 20% complete



Since your coverage depends on the information you provide on your application, it is vitally important that you answer each question accurately and honestly.

Supply Your Information

First Name: *	Middle Initial:	Last Name: *
<input type="text"/>	<input type="text"/>	<input type="text"/>
Primary Mailing Address: *		
<input type="text"/>		
City: *	State: *	ZIP: *
<input type="text"/>	<input type="text"/>	<input type="text"/>
Gender: *	Date of Birth: *	
<input type="radio"/> Male <input type="radio"/> Female	<input type="text"/>	
Phone #1: *	Phone #2:	
<input type="text"/>	<input type="text"/>	
Email Address: *	Coverage Amount: *	Have you smoked cigarettes in the last 12 months? *
<input type="text"/>	<input type="text"/>	<input type="radio"/> Yes <input type="radio"/> No
Height: *	Weight: *	Social Security Number: *
<input type="text"/> ft. <input type="text"/> in.	<input type="text"/> lbs	<input type="text"/>
U.S. Citizen: *	Marital Status: *	Annual Household Income: *
<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Single <input type="radio"/> Married	Select One <input type="text"/>
Occupation: *		
<input type="text"/>		

Choose Your Beneficiary

If no beneficiary survives the owner, or none is named, payment will be made to the owner's estate.

First Name:	Middle Initial:	Last Name:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Relationship:	Please Specify: *	Date of Birth:
Select One <input type="text"/>	<input type="text"/>	<input type="text"/>

Insurance Replacement

Do you intend to replace, discontinue, or change any existing life insurance policy? *

☒ Yes ☐ No

Please Provide Information about the life insurance company that issued the policy or annuity you wish to replace:

Life Insurance Company Name: *	<input type="text"/>
Policy or Contact Number: *	<input type="text"/>
Coverage Amount: *	<input type="text"/>

Proposed Insured

Is the person completing this application the proposed insured? *

☐ Yes ☐ No**Automatic Premium Loan Requested**

Automatic Premium Loan will protect you from having your Whole Life Insurance Policy cancelled because you didn't pay a premium on time. The premium will be paid for you, automatically, by a loan against available cash value in your policy.

Select yes below to select this option. *

☐ Yes ☐ No**CONTINUE**

Copyright 2012 AMERICAN NATIONAL INSURANCE COMPANY. All Rights Reserved.

American National Insurance Company, is headquartered at One Moody Plaza, Galveston TX 77550 and is licensed to conduct business in all states except New York. Business is conducted in New York by American National Life Insurance Company of New York, 344 Route 9W P.O. Box 505 Glenmont, NY 12077

Policies contain exclusions, limitation and terms for keeping them in force.



10582-C



877.698.0987



Live Support
OFFLINE

[ABOUT US](#) | [FAQS](#) | [PRIVACY](#) | [CONTACT US](#)

1 GET A QUOTE & CHOOSE COVERAGE

2 APPLY FOR INSTANT COVERAGE

3 PAYMENT OPTIONS

STEP-2: Apply For Instant Coverage

You are 30% complete



Since your coverage depends on the information you provide on your application, it is vitally important that you answer each question accurately and honestly.

1

Are you currently admitted to or confined to a hospital, mental institution, nursing home, assisted living center or receiving home health care or need assistance with eating, bathing or dressing?

☐ Yes ☐ No

2

Within the past 60 days, have you been advised by a member of the medical profession to get specified medical care which has not yet been completed or are still awaiting results, such as any hospitalization, surgery or diagnostic test, except those tests related to the Human Immunodeficiency Virus (AIDS virus)?

☐ Yes ☐ No

Explain:

3

Within the past 5 years, have you been: Diagnosed or treated by a member of the medical profession for a seizure or transient ischemic attack (TIA), hospitalized for depression or attempted suicide, diagnosed or treated by a member of the medical profession or received treatment or counseling for alcoholism, alcohol abuse or drug abuse, convicted of driving while intoxicated (DWI) or driving under the influence (DUI), convicted of a felony or been in prison?

☐ Yes ☐ No

CONTINUE

Copyright 2012 AMERICAN NATIONAL INSURANCE COMPANY. All Rights Reserved.

American National Insurance Company, is headquartered at One Moody Plaza, Galveston TX 77550 and is licensed to conduct business in all states except New York. Business is conducted in New York by American National Life Insurance Company of New York, 344 Route 9W P.O. Box 505 Glenmont, NY 12077

Policies contain exclusions, limitation and terms for keeping them in force.



10582-C



877.698.0987

Live Support
ONLINE[ABOUT US](#) | [FAQS](#) | [PRIVACY](#) | [CONTACT US](#)

1

GET A QUOTE & CHOOSE COVERAGE

2

APPLY FOR INSTANT COVERAGE

3

PAYMENT OPTIONS

STEP-2: Apply For Instant Coverage

You are 50% complete



Since your coverage depends on the information you provide on your application, it is vitally important that you answer each question accurately and honestly.

4

Within the past 10 years, have you been diagnosed or treated by a member of the medical profession for: musculoskeletal disorder, lupus, connective tissue disease, lung disease or disorder, clotting or bleeding disorder, anemia or blood disease, diabetes treated with insulin or requiring hospitalization, high blood pressure requiring more than 2 medications or hospitalization?

☐ Yes ☐ No

(Select all which are applicable):

☐ Musculoskeletal disorder, lupus, or other connective tissue disease.

Please indicate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as it relates to Musculoskeletal disorder, lupus, or other connective tissue disease (Select all that apply):

☐ Lupus

☐ Systemic Lupus

☐ Discoid Lupus or lupus that only involves the skin

☐ Other/unknown

Have you ever been hospitalized for this condition?

☐ Yes ☐ No

Are you considered disabled due to this condition?

☐ Yes ☐ No

Do your symptoms involve more than just a skin rash?

☐ Yes ☐ No

What treatment are you receiving for this condition? Explain:

<input type="checkbox"/> Rheumatoid Arthritis
<p>Are you considered disabled due to this condition?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Have you ever been hospitalized for this condition?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Do you require the walking aids or wheelchair?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Do you take steroids or Prednisone?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p>
<input type="checkbox"/> Mixed Connective Tissue Disease
<input type="checkbox"/> Polymyositis or dermatomyositis
<input type="checkbox"/> Fibromyalgia
<p>Are you currently being treated with steroids, Prednisone or narcotic pain medication?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p>
<input type="checkbox"/> Tendonitis or tenosynovitis
<input type="checkbox"/> Gout
<input type="checkbox"/> Osteoarthritis
<input type="checkbox"/> Osteomyelitis
<p>Is this a chronic condition?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Have you fully recovered?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Number of years since your last episode or attack?</p> <p><input type="radio"/> 0 to 3 years</p> <p><input type="radio"/> Over 3 years</p>
<input type="checkbox"/> Herniated disc or back sprain

Do you currently require use of narcotic pain medication?

☐ Yes ☐ No

☐ Osteoporosis

Does this condition cause any restrictions on activity or disability?

☐ Yes ☐ No

☐ Paget's disease of the Bone

Does this involve more than 2 bones?

☐ Yes ☐ No

Has this disease resulted in more than 1 fracture?

☐ Yes ☐ No

Are there any restrictions on activity?

☐ Yes ☐ No

Are you considered disabled due to this condition?

☐ Yes ☐ No

☐ Benign, Non-malignant bone or joint tumor(s)

Have you fully recovered with no evidence of recurrence?

☐ Yes ☐ No

Do you currently have any current tumor that has not been surgically removed?

☐ Yes ☐ No

When was most recent tumor removed?

☐ 0 to 3 years

☐ Over 3 years

☐ Malignant, cancerous bone or joint tumor(s)

☐ Polymyalgia Rheumatica

Have you had any treatment or symptoms within the past 2 years?

☐ Yes ☐ No

☐ Other

Explain:

☐ Lung disease or disorder

Please indicate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as it relates to lung disease or disorder (Select all that apply):

☐ Emphysema

☐ COPD (Chronic Obstructive Lung Disease) or Chronic Bronchitis

Have you smoked any tobacco products in the past 2 years?

☐ Yes ☐ No

Have you ever required oxygen treatment?

☐ Yes ☐ No

Have you been hospitalized in the past 5 years for COPD or chronic bronchitis?

☐ Yes ☐ No

Are you currently treated with oral steroids or Prednisone?

☐ Yes ☐ No

Do you currently have any restrictions on activity due to COPD or Chronic Bronchitis?

☐ Yes ☐ No

Are you considered disabled due to COPD or Chronic Bronchitis?

☐ Yes ☐ No

☐ Asthma

Have you been hospitalized in past 2 years for asthma?

☐ Yes ☐ No

Are you treated by oral steroids or Prednisone?

☐ Yes ☐ No

Do you currently have any restrictions on activity due to asthma?

☐ Yes ☐ No

Are you considered disabled due to asthma?

☐ Yes ☐ No

☐ Bronchiectasis

Have you ever required oxygen treatment?

☐ Yes ☐ No

Have you been hospitalized for bronchiectasis in the past 5 years?

☐ Yes ☐ No

Are you considered disabled due to bronchiectasis?

☐ Yes ☐ No

Do you currently have any restrictions on activity due to bronchiectasis?

☐ Yes ☐ No

☐ Bronchitis (non chronic)

☐ Pneumonia

Do you currently have pneumonia, have had pneumonia within the past 3 months or are recovering from pneumonia?

☐ Yes ☐ No

Have you fully recovered from pneumonia and have no further symptoms?

☐ Yes ☐ No

Have you been advised to have a follow-up Chest X-ray, CT-scan, MRI or other testing related to the lungs that has not been completed or that you are awaiting results?

☐ Yes ☐ No

Do you have any other lung or heart problems?

Explain:

☐ Pneumothorax (collapsed lung)

Did the pneumothorax occur within the past 6 months?

☐ Yes ☐ No

What was the cause of the pneumothorax?

- ☐ Spontaneous
- ☐ Trauma
- ☐ Other

Explain:

Have you fully recovered from the pneumothorax with no further symptoms?

- ☐ Yes ☐ No

☐ Pulmonary embolism (blood clot in lung)

Have you had more than one episode/event associated with a pulmonary embolism?

- ☐ Yes ☐ No

Have you had a pulmonary embolism within the past 2 years?

- ☐ Yes ☐ No

Do you require ongoing anticoagulant treatment (Coumadin or Warfarin) to prevent future blood clots?

- ☐ Yes ☐ No

Was the cause of the embolism due to another disease or disorder?

- ☐ Yes ☐ No

Explain:

☐ Pulmonary Hypertension

☐ Sarcoidosis

☐ Sleep Apnea

Were you diagnosed with sleep apnea within the past 6 months?

- ☐ Yes ☐ No

Have you been advised to use c-pap or bi-pap treatment?

☐ Yes ☐ No

Do you use recommended treatment?

☐ Yes ☐ No

Have you been advised to have a sleep study that has not yet been completed?

☐ Yes ☐ No

Do you currently suffer from excessive daytime fatigue?

☐ Yes ☐ No

☐ Lung cancer

☐ Other

Explain:

☐ Clotting or bleeding disorder, anemia or blood disease

Please indicate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as it relates to clotting or bleeding disorder, anemia or blood disease (select all that apply)

☐ Anemia

Have you been hospitalized for anemia in the past year?

☐ Yes ☐ No

Has your anemia caused you to receive a blood transfusion in the past 5 years?

☐ Yes ☐ No

Have you ever been diagnosed with cancer (excluding basal cell or squamous cell skin cancer), leukemia, lymphoma, multiple myeloma, or hemophilia or other bleeding/clotting disorder?

☐ Yes ☐ No

Have you been diagnosed with sickle cell anemia?

☐ Yes ☐ No

Have you been advised by a member of the medical profession that you have sickle cell trait only?

☐ Yes ☐ No

Have you ever been diagnosed with symptomatic sickle cell anemia or required any treatment for sickle cell anemia?

☐ Yes ☐ No

Was the cause of the anemia due to bleeding from the gastrointestinal tract?

☐ Yes ☐ No

Was the last occurrence of gastrointestinal bleeding within the past 2 years?

☐ Yes ☐ No

Was there any cancer or malignancy found to be the cause of the bleeding?

☐ Yes ☐ No

Have the symptoms fully resolved and anemia no longer present?

☐ Yes ☐ No

Have you had a colonoscopy with abnormal results in the past 2 years?

☐ Yes ☐ No

Have you been advised to have a colonoscopy or other testing involving the gastrointestinal tract that has not yet been completed?

☐ Yes ☐ No

☐ Other

Explain:

☐ Diabetes treated with insulin or requiring hospitalization

Please indicate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as it relates to diabetes treated with insulin or requiring hospitalization (select all that apply)

Have you been prescribed Insulin to treat your diabetes?

☐ Yes ☐ No

Have you been hospitalized in the past 5 years due to diabetes?

☐ Yes ☐ No

Have you ever been diagnosed with a diabetic coma in the past 10 years by a medical professional?

☐ Yes ☐ No

Have you been diagnosed by a member of the medical profession with heart disease, kidney disease, excessive protein or albumin in the urine, or blindness?

☐ Yes ☐ No

Have you had any limbs amputated due to diabetes or circulatory problems?

☐ Yes ☐ No

Have you ever required dialysis or been advised by a member of the medical profession that you need dialysis?

☐ Yes ☐ No

What was your most recent Hemoglobin A1c (HGB A1c, glycosylated hemoglobin) test result?

- ☐ 7.0 or less
☐ 7.1 - 9.99
☐ 10.0 or higher
☐ unknown

What was your most recent blood sugar test result?

- ☐ Below 145
☐ 145 to 220
☐ Over 220

Have you been prescribed oral medications or diet to treat your diabetes?

☐ Yes ☐ No

Have you been hospitalized in the past 5 years due to diabetes?

☐ Yes ☐ No

Have you ever been diagnosed with a diabetic coma in the past 10 years by a medical professional?

☐ Yes ☐ No

Have you had any limbs amputated due to diabetes or circulatory problems

☐ Yes ☐ No

Have you ever required dialysis or been advised by a member of the medical profession that you need dialysis?

☐ Yes ☐ No

What was your most recent Hemoglobin A1c (HGB A1c, glycosylated hemoglobin) test result?

- ☐ 7.0 or less
☐ 7.1 - 9.99
☐ 10.0 or higher
☐ unknown

What was your most recent blood sugar test result?

- ☐ Below 145
☐ 145 to 220
☐ Over 220

☐ High blood pressure requiring more than 2 medications or hospitalization

Please indicate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as it relates to high blood pressure requiring more than 2 medications or hospitalization (select all that apply)

In the past 6 months have you had a blood pressure reading over 160/100?

☐ Yes ☐ No

Have you ever been diagnosed with Stroke, Cerebral Vascular Accident (CVA), Transient Ischemic Attack (TIA), Heart Disease, Congestive Heart Failure, Peripheral Vascular disease, or disease or disorder of the heart valves?

☐ Yes ☐ No

Do you have any cardiac testing or procedures pending or advised to have completed that have not been completed?

☐ Yes ☐ No

Explain:

5

Within the past 10 years, have you been diagnosed or treated by a member of the medical profession for: heart attack, disease or abnormality of the heart or blood vessels, stroke, cerebral vascular accident (CVA), aneurysm, peripheral vascular disease, cancer (excluding basal and squamous cell skin cancer), leukemia, lymphoma, malignancy, nervous system disease or disorder, hepatitis C, kidney, liver, pancreas disease or disorder, Alzheimer's, schizophrenia, bipolar, mental disorder, or as having an acquired immune deficiency disease or disorder (AIDS), AIDS-Related Complex, or tested positive on an acquired immune deficiency syndrome-related test?

☐ Yes ☐ No

(Select all which are applicable):

☐ Heart attack or any disease or abnormality of the heart or blood vessels.

Please indicate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as it relates to heart attack or disease or abnormality of the heart or blood vessels. (Select all that apply):

☐ Heart Attack

☐ Stroke or Cerebral Vascular Accident (CVA)

☐ Coronary Artery Disease

☐ Coronary Bypass surgery, coronary angioplasty, or Stenting of coronary artery or arteries.

☐ Congestive Heart Failure

☐ Disease of the heart valve or valves

☐ Heart Murmur

Does your heart murmur cause any restrictions on activity?

☐ Yes ☐ No

Have you ever had any blackouts or fainting episodes due to your heart murmur?

☐ Yes ☐ No

Have you ever been diagnosed by a member of the medical profession with a disease or disorder of the heart valves?

☐ Yes ☐ No

Have you been diagnosed with Mitral Valve Prolapse (MVP)?

☐ Yes ☐ No

Does your Mitral Valve Prolapse cause any arrhythmias or palpitations or restrict activity in any way?

☐ Yes ☐ No

When was your most recent echocardiogram (ultrasound of heart)?

- ☐ within the last 6 months
- ☐ over 6 months ago
- ☐ never had an echocardiogram

Have you been advised to have an echocardiogram (ultrasound of heart) that has not yet been completed?

☐ Yes ☐ No

Do you have any other cardiac testing or procedures pending or advised to have completed that have not yet been completed?

☐ Yes ☐ No

Explain:

- ☐ Irregular heartbeat, palpitations, or arrhythmia
- ☐ High Blood Pressure or Hypertension
- ☐ Other

Explain:

- ☐ Stroke, cerebral vascular accident (CVA), aneurysm, or any peripheral vascular disease.
- ☐ Cancer (excluding basal and squamous cell skin cancer), leukemia, lymphoma, or any other malignancy.
- ☐ Acquired immune deficiency disease or disorder (AIDS), AIDS-Related Complex.
- ☐ Tested positive on an acquired immune deficiency syndrome-related test.
- ☐ Nervous system disorder or disease.

Please indicate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as it relates to nervous system disease or disorder. (Select all that apply):

- ☐ Dementia or cognitive disease or disorder
- ☐ Huntington's Disease
- ☐ Multiple Sclerosis
- ☐ Stroke or Cerebral Vascular Accident (CVA)
- ☐ Parkinson's Disease
- ☐ Amyotrophic Lateral Sclerosis (ALS) or Lou Gehrig's Disease
- ☐ Seizure disorder or epilepsy

Were you first diagnosed with seizure disorder or epilepsy within the past 2 years?

☐ Yes ☐ No

When was your last attack/episode of epilepsy or seizure?

- ☐ 0-3 years ago
☐ 3-7 years ago
☐ Over 7 years ago

Are you considered disabled due to seizure disorder or epilepsy?

☐ Yes ☐ No

Is seizure disorder or epilepsy caused by a brain or other nervous system tumor?

☐ Yes ☐ No

Do you have any testing or procedures that have been recommended by a member of the medical profession for seizure disorder or epilepsy that has not yet been completed?

☐ Yes ☐ No

Explain:

☐ Tremor

Has the tremor been present for less than 2 years?

☐ Yes ☐ No

Has the tremor been evaluated by a member of the medical profession and determined to be a benign, essential, or physiological tremor with no Parkinson's disease or other underlying cause?

☐ Yes ☐ No

Do you have any testing or procedures with respect to the tremor that have been recommended by a member of the medical profession that has not yet been completed?

☐ Yes ☐ No

Explain:

☐ Spinal Cord injury or disease

Please indicate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as it relates to spinal cord injury or disease (Select all that apply):

- ☐ Quadriplegia or tetraplegia
- ☐ Paraplegia or Paraparesis
- ☐ Hemiplegia or hemiparesis
- ☐ Non-paralyzing injury to spinal cord
- ☐ Spondylosis
- ☐ Herniated disc or compression of the spinal cord
- ☐ Other Spinal Cord disease, disorder or injury

Explain:

Do you currently use a wheel chair?

☐ Yes ☐ No

Do you currently require the use of narcotics to control pain?

☐ Yes ☐ No

Do you currently require walking aids?

☐ Yes ☐ No

Are you considered disabled due to the spinal cord injury or disease?

☐ Yes ☐ No

☐ Tumor of the nervous system or brain

Was the tumor considered cancerous or malignant?

☐ Yes ☐ No

Was the tumor a brain tumor?

☐ Yes ☐ No

Has the brain tumor been surgically removed?

☐ Yes ☐ No

Was the brain tumor removed within the past 10 years?

☐ Yes ☐ No

Do you have any neurological testing or procedure that has been recommended by a medical professional that has not yet been completed?

☐ Yes ☐ No

Explain:

Was the tumor a spinal cord tumor?

☐ Yes ☐ No

Was the tumor surgically removed

☐ Yes ☐ No

Was the tumor removed within the past 2 years?

☐ Yes ☐ No

Do you have any neurological testing or procedure that has been recommended by a medical professional that has not yet been completed?

☐ Yes ☐ No

Explain:

☐ Depression, Anxiety, or other psychological condition

Please indicate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as it relates to depression, anxiety, or other psychological condition: (Select all that apply):

☐ Bipolar

☐ Schizophrenia

☐ Depression

Have you been hospitalized for this condition in the past 5 years?

☐ Yes ☐ No

Have you ever attempted suicide?

☐ Yes ☐ No

Are you considered disabled due to this condition?

☐ Yes ☐ No

☐ Anxiety

Have you been hospitalized for this condition in the past 5 years?

☐ Yes ☐ No

Have you ever attempted suicide?

☐ Yes ☐ No

Are you considered disabled due to this condition?	
<input type="radio"/> Yes <input type="radio"/> No	
<input type="checkbox"/> Other Explain: <div></div>	
<input type="checkbox"/> Bells Palsy	
Have you been diagnosed by a member of the medical profession with Bells Palsy within the past 6 months?	
<input type="radio"/> Yes <input type="radio"/> No	
<input type="checkbox"/> Trigeminal Neuralgia	
Have you had surgery for trigeminal neuralgia?	
<input type="radio"/> Yes <input type="radio"/> No	
Have you fully recovered from the surgery?	
<input type="radio"/> Yes <input type="radio"/> No	
Has surgery been recommended that has not been completed?	
<input type="radio"/> Yes <input type="radio"/> No	
<input type="checkbox"/> Thoracic Outlet Syndrome	
<input type="checkbox"/> Narcolepsy	
Were you first diagnosed by a member of the medical profession with Narcolepsy within the past 2 years?	
<input type="radio"/> Yes <input type="radio"/> No	
Have you had any symptoms of narcolepsy in the past year?	
<input type="radio"/> Yes <input type="radio"/> No	
<input type="checkbox"/> Other nervous system disorder or disease	
Explain: <div></div>	
<input type="checkbox"/> Hepatitis C or any kidney, liver, pancreas disease or disorder.	

Please indicate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as it relates to hepatitis C or kidney, liver, pancreas disease or disorder. (Select all that apply):

☐ Kidney Disease

- ☐ Blockage of the renal (kidney) arteries
- ☐ Hypertensive renal (kidney) disease
- ☐ Cancer of the kidney
- ☐ Had dialysis or been advised to have dialysis?
- ☐ Kidney failure
- ☐ Glomerulonephritis, nephritic or nephrotic syndrome
- ☐ Polycystic kidney disease
- ☐ Kidney stones
- ☐ Kidney infection

Did your kidney infection occur in the past 3 months?

☐ Yes ☐ No

Have you fully recovered from your kidney infection

☐ Yes ☐ No

☐ Other

Explain:

☐ Hepatitis B or C

☐ Hepatitis A

Have you fully recovered from Hepatitis A?

☐ Yes ☐ No

- ☐ Non-viral hepatitis
- ☐ Enlarged liver
- ☐ Cirrhosis of the liver
- ☐ Primary Biliary Cirrhosis
- ☐ Primary Sclerosing Cholangitis
- ☐ Liver tumor or liver cancer

☐ Fatty liver

Have you been advised by member of the medical profession that your liver enzymes or liver function tests are abnormal or elevated?

☐ Yes ☐ No

Have you been advised by a member of the medial profession that the cause of fatty liver is related to alcohol use?

☐ Yes ☐ No

Have you had a liver biopsy or has a liver biopsy been recommended by a member of the medical profession?

☐ Yes ☐ No

Have you been diagnosed by a member of the medical profession with Non-Alcoholic Steatohepatitis (NASH)?

☐ Yes ☐ No

☐ Pancreatitis

☐ Tumor or Cancer of the Pancreas

☐ Crohn's or ulcerative colitis

Do you use steroids or immunosuppressive drugs for treatment?

☐ Yes ☐ No

Have you been hospitalized for Crohn's or ulcerative colitis in the past 5 years?

☐ Yes ☐ No

Did you require surgery or have you been advised by a member of the medical profession to have surgery for Crohn's or ulcerative colitis which has not been performed?

☐ Yes ☐ No

Have you had an attack of Crohn's or ulcerative colitis within the past year?

☐ Yes ☐ No

Does Crohn's or ulcerative colitis limit normal activity or are you considered disabled due to this condition?

☐ Yes ☐ No

Has a member of the medical profession advised you to have a colonoscopy or other test related to the gastrointestinal tract that has not been completed?

☐ Yes ☐ No

☐ Other

Explain:

☐ Alzheimer's, schizophrenia, bipolar or mental disorder.

Please indicate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as it relates to alzheimer's, schizophrenia, bipolar or mental disorder (select all that apply) :

☐ Alzheimer's
☐ Schizophrenia
☐ Bipolar
☐ Attempted Suicide
☐ Depression

Have you been hospitalized for this condition in the past 5 years?

☐ Yes ☐ No

Have you ever attempted suicide?

☐ Yes ☐ No

Are you considered disabled due to this condition?

☐ Yes ☐ No

☐ Anxiety

Have you been hospitalized for this condition in the past 5 years?

☐ Yes ☐ No

Have you ever attempted suicide?

☐ Yes ☐ No

Are you considered disabled due to this condition?

☐ Yes ☐ No

☐ Other

Explain:

CONTINUE 

Copyright 2012 AMERICAN NATIONAL INSURANCE COMPANY. All Rights Reserved.

American National Insurance Company, is headquartered at One Moody Plaza, Galveston TX 77550 and is licensed to conduct business in all states except New York. Business is conducted in New York by American National Life Insurance Company of New York, 344 Route 9W P.O. Box 505 Glenmont, NY 12077

Policies contain exclusions, limitation and terms for keeping them in force.



10582-C

If med question decline:



877.698.0987



Live Support
ONLINE

[ABOUT US](#) | [FAQS](#) | [PRIVACY](#) | [CONTACT US](#)

1

GET A QUOTE & CHOOSE COVERAGE

2

APPLY FOR INSTANT COVERAGE

3

PAYMENT OPTIONS

We're sorry, based on the information provided, the application process can not be completed online. If you would like to submit an application for consideration, please click the "Print Application" below, complete the application, make sure it's signed by the person to be covered, and mail it to:

American National Life Insurance Company
P.O. Box 696700
San Antonio, TX 78269

Note: You **MUST** have Adobe Acrobat Reader 5.0 or higher installed on your computer to view the online application. You may click on the "Get Acrobat Reader" logo to obtain a Free copy.

Click here to ["Print your application"](#).

Copyright 2012 AMERICAN NATIONAL INSURANCE COMPANY. All Rights Reserved.

American National Insurance Company, is headquartered at One Moody Plaza, Galveston TX 77550 and is licensed to conduct business in all states except New York. Business is conducted in New York by American National Life Insurance Company of New York, 344 Route 9W P.O. Box 505 Glenmont, NY 12077

Policies contain exclusions, limitation and terms for keeping them in force.



10582-C

Disclosure Page



877.698.0987



Live Support
ONLINE

[ABOUT US](#) | [FAQS](#) | [PRIVACY](#) | [CONTACT US](#)

1

GET A QUOTE & CHOOSE COVERAGE

2

APPLY FOR INSTANT APPROVAL

3

PAYMENT OPTIONS

STEP-2: Notice of Information Practices and Electronic Consent

You are 60% complete



Please review all disclosures carefully and agree to the following: Exchange of Information, MIB Pre-notifications, Fair Credit Act Pre-notification, USA PATRIOT Act Notice, Consent For Use Of Electronic Signatures and Statement of Electronic Disclosures:

[Print Disclosures](#)

See screen_appendix A for Call Center Path Disclosures

See screen_appendix B for Internet (Consumer) Path Disclosures

DECLINE

AGREE

Copyright 2012 AMERICAN NATIONAL INSURANCE COMPANY. All Rights Reserved.

American National Insurance Company, is headquartered at One Moody Plaza, Galveston TX 77550 and is licensed to conduct business in all states except New York. Business is conducted in New York by American National Life Insurance Company of New York, 344 Route 9W P.O. Box 505 Glenmont, NY 12077

Policies contain exclusions, limitation and terms for keeping them in force.



10582-C

If decline –



877.698.0987



Live Support
ONLINE

[ABOUT US](#) | [FAQS](#) | [PRIVACY](#) | [CONTACT US](#)

1

GET A QUOTE & CHOOSE COVERAGE

2

APPLY FOR INSTANT COVERAGE

3

PAYMENT OPTIONS

[Application process options](#)

Without the required acceptance of the Notice of Information Practices and Electronic Consent, we cannot continue online processing of your application.

- ☐ **Option 1:** Continue with electronic process.
- ☐ **Option 2:** I would prefer to print my application, sign it, and send it to American National Insurance Company. I understand that, if approved, I will receive my policy in the mail and that I must remit my initial premium before any insurance will go into effect.
- ☐ **Option 3:** Please discontinue processing my application. I understand that I may return at a future date and apply again but I will have to complete a new application at that time.

CONTINUE



Copyright 2012 AMERICAN NATIONAL INSURANCE COMPANY. All Rights Reserved.

American National Insurance Company, is headquartered at One Moody Plaza, Galveston TX 77550 and is licensed to conduct business in all states except New York. Business is conducted in New York by American National Life Insurance Company of New York, 344 Route 9W P.O. Box 505 Glenmont, NY 12077


Policies contain exclusions, limitation and terms for keeping them in force.





10582-C

Ex opt 1 – go to Disclosure Page

Ex opt 2 –



**877.698.0987**

**Live Support**
ONLINE

ABOUT US | FAQs | PRIVACY | CONTACT US

1 GET A QUOTE & CHOOSE COVERAGE **2** APPLY FOR INSTANT COVERAGE **3** PAYMENT OPTIONS

Important Reminder!

Processing can't begin until we receive your signed application.

Note: You **MUST** have Adobe Acrobat Reader® 5.0 or higher installed on your computer to view the online application. You may click [here](#) to obtain a FREE copy.

Please click [here](#) to see your application. Then review, print, sign, date and mail it to American National Insurance Company at the following address:



American National Insurance Company
P.O. BOX 696700
San Antonio, TX 78269

Your application, will be processed immediately upon receipt and, once approved, your policy will be mailed. The next screen will present the application as you've completed it to this point. Please don't delay - print and mail your application today! Thank you for considering American National Insurance Company for your life insurance needs. We look forward to receiving your application soon.


Copyright 2012 AMERICAN NATIONAL INSURANCE COMPANY. All Rights Reserved.


American National Insurance Company, is headquartered at One Moody Plaza, Galveston TX 77550 and is licensed to conduct business in all states except New York. Business is conducted in New York by American National Life Insurance Company of New York, 344 Route 9W P.O. Box 505 Glenmont, NY 12077


Policies contain exclusions, limitation and terms for keeping them in force.

**10582-C**

Ex opt 3 –



**877.698.0987**

**Live Support**
ONLINE

ABOUT US | FAQs | PRIVACY | CONTACT US

1 GET A QUOTE & CHOOSE COVERAGE **2** APPLY FOR INSTANT COVERAGE **3** PAYMENT OPTIONS



Thank You!

Thank you for considering American National Insurance Company for your life insurance needs. We're sorry we were unable to meet your needs at this time but we hope you will return to our site the next time you consider providing financial security for your family.

Copyright 2012 AMERICAN NATIONAL INSURANCE COMPANY. All Rights Reserved.

American National Insurance Company, is headquartered at One Moody Plaza, Galveston TX 77550 and is licensed to conduct business in all states except New York. Business is conducted in New York by American National Life Insurance Company of New York, 344 Route 9W P.O. Box 505 Glenmont, NY 12077

Policies contain exclusions, limitation and terms for keeping them in force.

**10582-C**

If agree from Disclosure Page – App is scrollable to review entire app (top of app)



877.698.0987



Live Support
ONLINE

[ABOUT US](#) | [FAQS](#) | [PRIVACY](#) | [CONTACT US](#)

1 GET A QUOTE & CHOOSE COVERAGE

2 APPLY FOR INSTANT COVERAGE

3 PAYMENT OPTIONS

STEP-2: Electronic Signature

Electronic signature must be completed.

You are 70% complete

e-Signature Process:

On the next several screens you will be prompted to add your electronic signature to the application and any other related documents and/or disclosures. Please review each document carefully for accuracy, completeness and to make sure that you understand and agree. By clicking on the sign button below, you will be agreeing to all terms & conditions described in each document. This will result in an enforceable legal document, just as if you had signed your name to a paper agreement. Failure to sign all of the items will result in our being unable to process your application online. You will still be eligible for this valuable coverage but we will have to delay the start until we can complete all of the requirements by mail.

Application For Individual Life Insurance		American National Insurance Company P.O. Box 696700 San Antonio, TX 78269
Your Details:		Your Spouse's Details (if applying):
Name: Mr. Edward Paul		Name: _____
Address: 123 Main Street Apt. _____		Address: _____ Apt. _____
City: Houston State: TX Zip Code: 77002		City: _____ State: _____ Zip Code: _____
Phone #1: (409) 111-1111 Phone #2: (409) 111-1111		Phone #1: () Phone #2: ()
E-mail: na@na.com		E-mail: _____
Social Security Number: 123 - 45 - 6789		Social Security Number: _____ - _____ - _____
Date of Birth: 04 / 05 / 1979		Date of Birth: ____ / ____ / ____
<input type="checkbox"/> Female <input checked="" type="checkbox"/> Male Height: 6 ft. 01 in. Weight: 210		<input type="checkbox"/> Female <input type="checkbox"/> Male Height: ____ ft. ____ in. Weight: ____
Are you a U.S. Citizen? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Are you a U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No
If 'No', do you have a permanent residence status? <input type="checkbox"/> Yes <input type="checkbox"/> No		If 'No', do you have a permanent residence status? <input type="checkbox"/> Yes <input type="checkbox"/> No
Annual Household Income: <input type="checkbox"/> Under \$10,000 <input type="checkbox"/> \$10,000 - \$24,999		Annual Household Income: <input type="checkbox"/> Under \$10,000 <input type="checkbox"/> \$10,000 - \$24,999
<input type="checkbox"/> \$25,000 - \$49,999 <input type="checkbox"/> \$50,000 - \$99,999 <input checked="" type="checkbox"/> \$100,000+		<input type="checkbox"/> \$25,000 - \$49,999 <input type="checkbox"/> \$50,000 - \$99,999 <input type="checkbox"/> \$100,000+
Marital Status: <input type="checkbox"/> Single <input checked="" type="checkbox"/> Married		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married
Have you smoked cigarettes in the last 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Have you smoked cigarettes in the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No

E-SIGN AND CONTINUE

Copyright 2012 AMERICAN NATIONAL INSURANCE COMPANY. All Rights Reserved.

American National Insurance Company, is headquartered at One Moody Plaza, Galveston TX 77550 and is licensed to conduct business in all states except New York. Business is conducted in New York by American National Life Insurance Company of New York, 344 Route 9W P.O. Box 505 Glenmont, NY 12077

Policies contain exclusions, limitation and terms for keeping them in force.



10582-C

Bottom of app... cont...



877.698.0987



Live Support
ONLINE

[ABOUT US](#) | [FAQS](#) | [PRIVACY](#) | [CONTACT US](#)

1 GET A QUOTE & CHOOSE COVERAGE

2 APPLY FOR INSTANT COVERAGE

3 PAYMENT OPTIONS

STEP-2: Electronic Signature

Electronic signature must be completed.

You are 70% complete

e-Signature Process:

On the next several screens you will be prompted to add your electronic signature to the application and any other related documents and/or disclosures. Please review each document carefully for accuracy, completeness and to make sure that you understand and agree. By clicking on the sign button below, you will be agreeing to all terms & conditions described in each document. This will result in an enforceable legal document, just as if you had signed your name to a paper agreement. Failure to sign all of the items will result in our being unable to process your application online. You will still be eligible for this valuable coverage but we will have to delay the start until we can complete all of the requirements by mail.

I understand and agree: that the answers in this application are, to the best of my knowledge and belief, complete and true; that the answers will be relied upon to determine if coverage will be issued and the amount of premium that will be charged and will become a part of the Policy; that any material misstatement or omissions may cause the policy to be void; that the Company will have no liability until a policy is issued and the first premium due is paid in full while I am alive and in the same health condition as described above; that if my spouse and I request life insurance on this application that my personal financial and health information written on it will be made part of the policy issued to not only me but also my spouse; and that if I do not agree, I may contact the Company and receive a separate application.

I authorize any physician, medical practitioner, hospital, clinic, pharmacy, pharmacy benefit manager or other medical-related facility, insurance company, MIB, Inc. or other organization that has any records concerning health or medical care, advice or treatment provided to me to give any such information to American National Insurance Company, or to any agent or agency acting on its behalf or to its reinsurer(s). I authorize the Company, or its reinsurers, to make a brief report of my personal health information to MIB.

Signature of Edward Paul
E-Signed 01/01/2013 by

Your Signature: X

Date: X 01 / 01 / 2013

Inc. I understand: that the Company will use this information to determine my eligibility for life insurance and the premium amount; that I may refuse to sign this authorization and that my refusal will affect my ability to obtain insurance; that such information may be subject to redisclosure and if so may no longer be protected by federal privacy law; that this authorization shall be valid for 24 months from the date signed and a copy will be as valid as the original; and that I have the right to revoke this authorization at any time, except to the extent that action has been taken in reliance thereon, by sending written notice to: the Company at the above address.

- I have read the Consumer Disclosure on the Sale of Insurance accompanying this application.

- I acknowledge receiving the Exchange of Information Notice.

- I have received and read the Summary and Disclosure Notice for Accelerated Benefits.

- **Fraud Warning:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Your Spouse's Signature: X _____

Date: X ____ / ____ / ____

E-SIGN AND CONTINUE

Copyright 2012 AMERICAN NATIONAL INSURANCE COMPANY. All Rights Reserved.


American National Insurance Company, is headquartered at One Moody Plaza, Galveston TX 77550 and is licensed to conduct business in all states except New York. Business is conducted in New York by American National Life Insurance Company of New York, 344 Route 9W P.O. Box 505 Glenmont, NY 12077


Policies contain exclusions, limitation and terms for keeping them in force.




10582-C

Approve –



**877.698.0987**

**Live Support**
ONLINE

ABOUT US | FAQs | PRIVACY | CONTACT US

1 GET A QUOTE & CHOOSE COVERAGE

2 APPLY FOR INSTANT COVERAGE

3 PAYMENT OPTIONS


STEP-2: Approved

You are 80% complete

[Congratulations! You've been approved!](#)

Your new policy number is **D400xxxxx**. Your policy will be mailed to you and you can expect to receive it in 5 to 7 days.





Great news, you are almost done! Please click the continue button to complete the online payment process so your valuable coverage can go into effect quickly.



CONTINUE 

Copyright 2012 AMERICAN NATIONAL INSURANCE COMPANY. All Rights Reserved.

American National Insurance Company, is headquartered at One Moody Plaza, Galveston TX 77550 and is licensed to conduct business in all states except New York. Business is conducted in New York by American National Life Insurance Company of New York, 344 Route 9W P.O. Box 505 Glenmont, NY 12077


Policies contain exclusions, limitation and terms for keeping them in force.







10582-C

RTU



**877.698.0987**

**Live Support**
ONLINE

ABOUT US | FAQs | PRIVACY | CONTACT US

1 GET A QUOTE & CHOOSE COVERAGE

2 APPLY FOR INSTANT COVERAGE


3 PAYMENT OPTIONS

STEP-2: Referred to an Underwriter

You are 80% complete

[Application Referred to Underwriter](#)





Thank you for your application. Your new policy number is **D400xxxxx**. It has been referred to an underwriter for further evaluation. To avoid delays, please proceed and select your payment option. Be assured that nothing will be charged or deducted until your policy has been approved. You will be hearing from us in the next few days regarding the results of the review process.



CONTINUE 

Copyright 2012 AMERICAN NATIONAL INSURANCE COMPANY. All Rights Reserved.


American National Insurance Company, is headquartered at One Moody Plaza, Galveston TX 77550 and is licensed to conduct business in all states except New York. Business is conducted in New York by American National Life Insurance Company of New York, 344 Route 9W P.O. Box 505 Glenmont, NY 12077

Policies contain exclusions, limitation and terms for keeping them in force.





10582-C

 Application For Individual Life Insurance		American National Insurance Company P.O. Box 696700 San Antonio, TX 78269
Your Details:	Your Spouse's Details (if applying):	
<p>Name: <u>Mr. Edward Paul</u></p> <p>Address: <u>123 Main Street</u></p> <p>City: <u>Little Rock</u> State: <u>AR</u> Zip Code: <u>72201</u></p> <p>Phone #1: <u>(501) 111-1111</u> Phone #2: <u>(501) 111-1111</u></p> <p>E-mail: <u>na@na.com</u></p> <p>Social Security Number: <u>123</u> - <u>45</u> - <u>6789</u></p> <p>Date of Birth: <u>04</u> / <u>05</u> / <u>1979</u></p> <p><input type="checkbox"/> Female <input checked="" type="checkbox"/> Male Height: <u>6</u> ft. <u>01</u> in. Weight: <u>210</u></p> <p>Are you a U.S. Citizen? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If 'No', do you have a permanent residence status? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Annual Household Income: <input type="checkbox"/> Under \$10,000 <input type="checkbox"/> \$10,000 - \$24,999 <input type="checkbox"/> \$25,000 - \$49,999 <input checked="" type="checkbox"/> \$50,000 - \$99,999 <input type="checkbox"/> \$100,000+</p> <p>Marital Status: <input type="checkbox"/> Single <input checked="" type="checkbox"/> Married</p> <p>Have you smoked cigarettes in the last 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Occupation: <u>franchise owner</u></p>		
<p>Name: _____</p> <p>Address: _____</p> <p>City: _____ State: _____ Zip Code: _____</p> <p>Phone #1: (____) _____ Phone #2: (____) _____</p> <p>E-mail: _____</p> <p>Social Security Number: _____ - _____ - _____</p> <p>Date of Birth: ____ / ____ / ____</p> <p><input type="checkbox"/> Female <input type="checkbox"/> Male Height: ____ ft. ____ in. Weight: _____</p> <p>Are you a U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No If 'No', do you have a permanent residence status? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Annual Household Income: <input type="checkbox"/> Under \$10,000 <input type="checkbox"/> \$10,000 - \$24,999 <input type="checkbox"/> \$25,000 - \$49,999 <input type="checkbox"/> \$50,000 - \$99,999 <input type="checkbox"/> \$100,000+</p> <p>Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married</p> <p>Have you smoked cigarettes in the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Occupation: _____</p>		
Your Amount of Coverage & Beneficiary:	Your Spouse's Coverage & Beneficiary:	
<p>Plan: <u>BudgetGuard 7 Year Term</u></p> <p>Amount (choose one):</p> <p><input type="checkbox"/> \$250,000 <input type="checkbox"/> \$150,000</p> <p><input type="checkbox"/> \$100,000 <input checked="" type="checkbox"/> Other: \$ <u>25,000.00</u></p> <p>Beneficiary: _____</p> <p>Date of Birth: <u>03</u> / <u>10</u> / <u>1980</u> Relationship: <u>Spouse</u></p> <p>Automatic Premium Loan Provision Requested? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>IMPORTANT: Do you intend to replace, discontinue, or change any existing life insurance policy? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>If 'Yes', name of company and policy number(s) if available: _____</p>		
<p>Plan: _____</p> <p>Amount (choose one):</p> <p><input type="checkbox"/> \$250,000 <input type="checkbox"/> \$150,000</p> <p><input type="checkbox"/> \$100,000 <input type="checkbox"/> Other: \$ _____</p> <p>Beneficiary: _____</p> <p>Date of Birth: ____ / ____ / ____ Relationship: _____</p> <p>Automatic Premium Loan Provision Requested? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>IMPORTANT: Do you intend to replace, discontinue, or change any existing life insurance policy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If 'Yes', name of company and policy number(s) if available: _____</p>		
Your Health:	Your Spouse's Health (if applying):	
<p>1. Within the past 10 years, have you been diagnosed or treated by a member of the medical profession for: heart attack, disease or abnormality of the heart or blood vessels, stroke, cerebral vascular accident (CVA), aneurysm, peripheral vascular disease, cancer (excluding basal and squamous cell skin cancer), leukemia, lymphoma, malignancy, nervous system disease or disorder, hepatitis C, kidney, liver, pancreas disease or disorder, Alzheimer's, schizophrenia, bipolar, mental disorder, or as having an acquired immune deficiency disease or disorder (AIDS), AIDS-Related Complex, or tested positive on an acquired immune deficiency syndrome-related test?</p> <p><u>You</u> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>		
<p><u>Your Spouse</u> <input type="checkbox"/> Yes <input type="checkbox"/> No</p>		

10582-AR

continued on back...

ADLXXX(F)

Your Health:	Your Spouse's Health (if applying):
---------------------	--

Your Health:	Your Spouse's Health (if applying):
---------------------	--

2. Within the past 5 years, have you been: Diagnosed or treated by a member of the medical profession for a seizure or transient ischemic attack (TIA), hospitalized for depression or attempted suicide, diagnosed or treated by a member of the medical profession or received treatment or counseling for alcoholism, alcohol abuse or drug abuse, convicted of driving while intoxicated (DWI) or driving under the influence (DUI), convicted of a felony or been in prison?

You ☐ Yes ☒ No

Your Spouse ☐ Yes ☐ No

3. Are you currently admitted to or confined to a hospital, mental institution, nursing home, assisted living center or receiving home health care or need assistance with eating, bathing or dressing?

You ☐ Yes ☒ No

Your Spouse ☐ Yes ☐ No

4. Within the past 10 years, have you been diagnosed or treated by a member of the medical profession for: musculoskeletal disorder, lupus, connective tissue disease, lung disease or disorder, clotting or bleeding disorder, anemia or blood disease, diabetes treated with insulin or requiring hospitalization, high blood pressure requiring more than 2 medications or hospitalization? If "Yes", provide details below (dates of treatment, test results, diagnoses, medications, etc.)

You ☐ Yes ☒ No Details: _____

Your Spouse ☐ Yes ☐ No Details: _____

5. Within the past 60 days, have you been advised by a member of the medical profession to get specified medical care which has not yet been completed or are still awaiting results, such as any hospitalization, surgery or diagnostic test, except those tests related to the Human Immunodeficiency Virus (AIDS virus)? If "Yes", provide details below:

You ☐ Yes ☒ No Details: _____

Your Spouse ☐ Yes ☐ No Details: _____

If you have more details, please include them on a separate sheet of paper

Your Payment — choose one:

I/we authorize the collection of premiums for the policy or policies as follows.

1. ☒ Automatic monthly deductions from my checking or savings account.
(Enclose a voided check when providing checking account and a deposit slip when providing savings account.)

2. ☐ Charge monthly premiums to my: ☐ Visa ☐ MasterCard ☐ Discover

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

--	--

 /

--	--
3. ☐ Bill me/us. (Send no money now.) (Account Number) (Exp. Date)

Agreements and Your Authorization to Obtain, Release and Disclose Medical Information:

I understand and agree: that the answers in this application are, to the best of my knowledge and belief, complete and true; that the answers will be relied upon to determine if coverage will be issued and the amount of premium that will be charged and will become a part of the Policy; that any material misstatement or omissions may cause the policy to be void; that the Company will have no liability until a policy is issued and the first premium due is paid in full while I am alive and in the same health condition as described above; that if my spouse and I request life insurance on this application that my personal financial and health information written on it will be made part of the policy issued to not only me but also my spouse; and that if I do not agree, I may contact the Company and receive a separate application.

I authorize any physician, medical practitioner, hospital, clinic, pharmacy, pharmacy benefit manager or other medical-related facility, insurance company, MIB, Inc. or other organization that has any records concerning health or medical care, advice or treatment provided to me to give any such information to American National Insurance Company, or to any agent or agency acting on its behalf or to its reinsurer(s). I authorize the Company, or its reinsurers, to make a brief report of my personal health information to MIB, Inc. on or before 01/01/2013.

E-Signed 01/01/2013 By
 Your Signature: X Edward Paul

Date: X 01 / 01 / 2013

Inc. I understand: that the Company will use this information to determine my eligibility for life insurance and the premium amount; that I may refuse to sign this authorization and that my refusal will affect my ability to obtain insurance; that such information may be subject to redisclosure and if so may no longer be protected by federal privacy law; that this authorization shall be valid for 24 months from the date signed and a copy will be as valid as the original; and that I have the right to revoke this authorization at any time, except to the extent that action has been taken in reliance thereon, by sending written notice to: the Company at the above address.

- I have read the Consumer Disclosure on the Sale of Insurance accompanying this application.
- I acknowledge receiving the Exchange of Information Notice.
- I have received and read the Summary and Disclosure Notice for Accelerated Benefits.
- **Fraud Warning:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Your Spouse's Signature: X _____

Date: X / /

ADLAXXX(B)

Screen appendix A – Call Center Path

Exchange of Information, Medical Information Bureau, Inc. Pre-notifications, Fair Credit Reporting Act and USA Patriot Act Notices: -

Exchange of Information Notice

We are required to provide the following disclosures to you: Medical Information Bureau, Inc. (MIB) Pre-Notification Information regarding your insurability will be treated as confidential. American National Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734. American National Insurance Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

Fair Credit Reporting Act Pre-notification

We may obtain an investigative consumer report in connection with your application. This report may contain information about your character, general reputation, personal characteristics or mode of living gathered from personal interviews with persons who may be acquainted with you. The information is kept confidential. You have the right to additional information about the nature and scope of the investigation provided you submit your request in writing within a reasonable period of time. We will inform you whether an investigative consumer report was requested and provide you with contact information for the agency preparing the report. By contacting the agency and providing proper identification, you may inspect or receive a copy of such report. A summary of your rights may be found on the Internet at www.ftc.gov/credit.

USA Patriot Act Notice

The USA Patriot Act requires that we establish an Anti-Money Laundering ('AML') Program, notify customers that we must verify the identity of the owner(s) of our contracts that have cash value, and collect information sufficient to verify identity. Failure to provide us identification information may result in the delay of issuance of coverage and may result in a decision not to accept your business.

Consent For Use Of Electronic Signatures and Records

American National Insurance Company is required by law to provide you with certain disclosures and information about your life insurance application. This part of the notice requires you to consent to the use of electronic signatures in connection with your application. This consent will allow the representative to electronically sign on your behalf, the application documents for which you have just provided information. Even if you consent to use electronic signatures, paper copies of the application documents will be sent to you with your policy for your review.

Application Disclosure


You understand and agree: that the answers in this application are, to the best of your knowledge and belief, complete and true; that the answers will be relied upon to determine if coverage will be issued and the amount of premium that will be charged and will become a part of the Policy; that any material misstatement or omissions may cause the policy to be void; that the Company will have no liability until a policy is issued and the first premium due is paid in full while you are alive and in the same health condition as described above; that if your spouse and you request life insurance on this application that your personal financial and health information written on it will be made part of the policy issued to not only you but also your spouse; and that if you do not agree, you may contact the Company and receive a separate application. You authorize any physician, medical practitioner, hospital, clinic, pharmacy, pharmacy benefit manager or other medical-related facility, insurance company, MIB, Inc. or other organization that has any records concerning health or medical care, advice or treatment provided to you to give any such information to American National Insurance Company, or to any agent or agency acting on its behalf or to its reinsurer(s). You authorize the Company, or its reinsurers, to make a brief report of your personal health information to MIB, Inc. You understand: that the Company will use this information to determine your eligibility for life insurance and the premium amount; that you may refuse to sign this authorization and that your refusal will affect your ability to obtain insurance; that such information may be subject to redisclosure and if so may no longer be protected by federal privacy law; that this authorization shall be valid for 24 months from the date signed and a copy will be as valid as the original; and that you have the right to revoke this authorization at any time, except to the extent that action has been taken in reliance thereon, by sending written notice to: the Company at the above address.


- You have read the Consumer Disclosure on the Sale of Insurance accompanying this application.
- You acknowledge receiving the Exchange of Information Notice.
- You have received and read the Summary and Disclosure Notice for Accelerated Benefits.

Fraud Warning: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Appendix C -

Website template subject to change (indicated in red boxes below – header and footer):



877.698.0987Live Support
ONLINE

ABOUT US | FAQs | PRIVACY | CONTACT US

1 GET A QUOTE & CHOOSE COVERAGE

2 APPLY FOR INSTANT COVERAGE

3 PAYMENT OPTIONS

STEP-2: Apply For Instant Coverage





You are 20% complete



All asterisked * fields must be completed.

Copyright 2012 AMERICAN NATIONAL INSURANCE COMPANY. All Rights Reserved.

American National Insurance Company, is headquartered at One Moody Plaza, Galveston TX 77550 and is licensed to conduct business in all states except New York. Business is conducted in New York by American National Life Insurance Company of New York, 344 Route 9W P.O. Box 505 Glenmont, NY 12077

Policies contain exclusions, limitation and terms for keeping them in force.





10582-C



877.698.0987

Live Support
ONLINE

[ABOUT US](#) | [FAQS](#) | [PRIVACY](#) | [CONTACT US](#)

1 GET A QUOTE & CHOOSE COVERAGE

2 APPLY FOR INSTANT COVERAGE

3 PAYMENT OPTIONS

STEP-2: Apply For Instant Coverage

All asterisked * fields must be completed.

You are 20% complete

Since your coverage depends on the information you provide on your application, it is vitally important that you answer each question accurately and honestly.

Supply Your Information

First Name: *	Middle Initial:	Last Name: *
<input type="text"/>	<input type="text"/>	<input type="text"/>
Primary Mailing Address: *		
<input type="text"/>		
City: *	State: *	ZIP: *
<input type="text"/>	<input type="text"/>	<input type="text"/>
Gender: *	Date of Birth: *	
<input type="radio"/> Male <input type="radio"/> Female	<input type="text"/>	
Phone #1: *		Phone #2:
<input type="text"/>		<input type="text"/>
Email Address: *	Coverage Amount: *	Have you smoked cigarettes in the last 12 months? *
<input type="text"/>	<input type="text"/>	<input type="radio"/> Yes <input type="radio"/> No
Height: *	Weight: *	Social Security Number: *
<input type="text"/> ft. <input type="text"/> in.	<input type="text"/> lbs	<input type="text"/>
U.S. Citizen: *	Marital Status: *	Annual Household Income: *
<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Single <input type="radio"/> Married	Select One <input type="text"/>
Occupation: *		
<input type="text"/>		

Choose Your Beneficiary

If no beneficiary survives the owner, or none is named, payment will be made to the owner's estate.

First Name:	Middle Initial:	Last Name:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Relationship:	Please Specify: *	Date of Birth:
Select One <input type="text"/>	<input type="text"/>	<input type="text"/>

Insurance Replacement

Do you intend to replace, discontinue, or change any existing life insurance policy? *

☒ Yes ☐ No

Please Provide Information about the life insurance company that issued the policy or annuity you wish to replace:

Life Insurance Company Name: *	<input type="text"/>
Policy or Contact Number: *	<input type="text"/>
Coverage Amount: *	<input type="text"/>

Proposed Insured

Is the person completing this application the proposed insured? *

☐ Yes ☐ No

Automatic Premium Loan Requested

Automatic Premium Loan will protect you from having your Whole Life Insurance Policy cancelled because you didn't pay a premium on time. The premium will be paid for you, automatically, by a loan against available cash value in your policy.

Select yes below to select this option.*

☐ Yes ☐ No

CONTINUE

Copyright 2012 AMERICAN NATIONAL INSURANCE COMPANY. All Rights Reserved.

American National Insurance Company, is headquartered at One Moody Plaza, Galveston TX 77550 and is licensed to conduct business in all states except New York. Business is conducted in New York by American National Life Insurance Company of New York, 344 Route 9W P.O. Box 505 Glenmont, NY 12077

Policies contain exclusions, limitation and terms for keeping them in force.



10582-I



877.698.0987



Live Support
OFFLINE

[ABOUT US](#) | [FAQS](#) | [PRIVACY](#) | [CONTACT US](#)

1 GET A QUOTE & CHOOSE COVERAGE

2 APPLY FOR INSTANT COVERAGE

3 PAYMENT OPTIONS

STEP-2: Apply For Instant Coverage

You are 30% complete



Since your coverage depends on the information you provide on your application, it is vitally important that you answer each question accurately and honestly.

1

Are you currently admitted to or confined to a hospital, mental institution, nursing home, assisted living center or receiving home health care or need assistance with eating, bathing or dressing?

☐ Yes ☐ No

2

Within the past 60 days, have you been advised by a member of the medical profession to get specified medical care which has not yet been completed or are still awaiting results, such as any hospitalization, surgery or diagnostic test, except those tests related to the Human Immunodeficiency Virus (AIDS virus)?

☐ Yes ☐ No

Explain:

3

Within the past 5 years, have you been: Diagnosed or treated by a member of the medical profession for a seizure or transient ischemic attack (TIA), hospitalized for depression or attempted suicide, diagnosed or treated by a member of the medical profession or received treatment or counseling for alcoholism, alcohol abuse or drug abuse, convicted of driving while intoxicated (DWI) or driving under the influence (DUI), convicted of a felony or been in prison?

☐ Yes ☐ No

CONTINUE

Copyright 2012 AMERICAN NATIONAL INSURANCE COMPANY. All Rights Reserved.

American National Insurance Company, is headquartered at One Moody Plaza, Galveston TX 77550 and is licensed to conduct business in all states except New York. Business is conducted in New York by American National Life Insurance Company of New York, 344 Route 9W P.O. Box 505 Glenmont, NY 12077

Policies contain exclusions, limitation and terms for keeping them in force.



10582-I



877.698.0987

Live Support
ONLINE[ABOUT US](#) | [FAQS](#) | [PRIVACY](#) | [CONTACT US](#)

1

GET A QUOTE & CHOOSE COVERAGE

2

APPLY FOR INSTANT COVERAGE

3

PAYMENT OPTIONS

STEP-2: Apply For Instant Coverage

You are 50% complete



Since your coverage depends on the information you provide on your application, it is vitally important that you answer each question accurately and honestly.

4

Within the past 10 years, have you been diagnosed or treated by a member of the medical profession for: musculoskeletal disorder, lupus, connective tissue disease, lung disease or disorder, clotting or bleeding disorder, anemia or blood disease, diabetes treated with insulin or requiring hospitalization, high blood pressure requiring more than 2 medications or hospitalization?

☐ Yes ☐ No

(Select all which are applicable):

☐ Musculoskeletal disorder, lupus, or other connective tissue disease.

Please indicate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as it relates to Musculoskeletal disorder, lupus, or other connective tissue disease (Select all that apply):

☐ Lupus

☐ Systemic Lupus

☐ Discoid Lupus or lupus that only involves the skin

☐ Other/unknown

Have you ever been hospitalized for this condition?

☐ Yes ☐ No

Are you considered disabled due to this condition?

☐ Yes ☐ No

Do your symptoms involve more than just a skin rash?

☐ Yes ☐ No

What treatment are you receiving for this condition? Explain:

<input type="checkbox"/> Rheumatoid Arthritis
<p>Are you considered disabled due to this condition?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Have you ever been hospitalized for this condition?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Do you require the walking aids or wheelchair?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Do you take steroids or Prednisone?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p>
<input type="checkbox"/> Mixed Connective Tissue Disease
<input type="checkbox"/> Polymyositis or dermatomyositis
<input type="checkbox"/> Fibromyalgia
<p>Are you currently being treated with steroids, Prednisone or narcotic pain medication?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p>
<input type="checkbox"/> Tendonitis or tenosynovitis
<input type="checkbox"/> Gout
<input type="checkbox"/> Osteoarthritis
<input type="checkbox"/> Osteomyelitis
<p>Is this a chronic condition?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Have you fully recovered?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Number of years since your last episode or attack?</p> <p><input type="radio"/> 0 to 3 years</p> <p><input type="radio"/> Over 3 years</p>
<input type="checkbox"/> Herniated disc or back sprain

Do you currently require use of narcotic pain medication?

☐ Yes ☐ No

☐ Osteoporosis

Does this condition cause any restrictions on activity or disability?

☐ Yes ☐ No

☐ Paget's disease of the Bone

Does this involve more than 2 bones?

☐ Yes ☐ No

Has this disease resulted in more than 1 fracture?

☐ Yes ☐ No

Are there any restrictions on activity?

☐ Yes ☐ No

Are you considered disabled due to this condition?

☐ Yes ☐ No

☐ Benign, Non-malignant bone or joint tumor(s)

Have you fully recovered with no evidence of recurrence?

☐ Yes ☐ No

Do you currently have any current tumor that has not been surgically removed?

☐ Yes ☐ No

When was most recent tumor removed?

☐ 0 to 3 years

☐ Over 3 years

☐ Malignant, cancerous bone or joint tumor(s)

☐ Polymyalgia Rheumatica

Have you had any treatment or symptoms within the past 2 years?

☐ Yes ☐ No

☐ Other

Explain:

☐ Lung disease or disorder

Please indicate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as it relates to lung disease or disorder (Select all that apply):

☐ Emphysema

☐ COPD (Chronic Obstructive Lung Disease) or Chronic Bronchitis

Have you smoked any tobacco products in the past 2 years?

☐ Yes ☐ No

Have you ever required oxygen treatment?

☐ Yes ☐ No

Have you been hospitalized in the past 5 years for COPD or chronic bronchitis?

☐ Yes ☐ No

Are you currently treated with oral steroids or Prednisone?

☐ Yes ☐ No

Do you currently have any restrictions on activity due to COPD or Chronic Bronchitis?

☐ Yes ☐ No

Are you considered disabled due to COPD or Chronic Bronchitis?

☐ Yes ☐ No

☐ Asthma

Have you been hospitalized in past 2 years for asthma?

☐ Yes ☐ No

Are you treated by oral steroids or Prednisone?

☐ Yes ☐ No

Do you currently have any restrictions on activity due to asthma?

☐ Yes ☐ No

Are you considered disabled due to asthma?

☐ Yes ☐ No

☐ Bronchiectasis

Have you ever required oxygen treatment?

☐ Yes ☐ No

Have you been hospitalized for bronchiectasis in the past 5 years?

☐ Yes ☐ No

Are you considered disabled due to bronchiectasis?

☐ Yes ☐ No

Do you currently have any restrictions on activity due to bronchiectasis?

☐ Yes ☐ No

☐ Bronchitis (non chronic)

☐ Pneumonia

Do you currently have pneumonia, have had pneumonia within the past 3 months or are recovering from pneumonia?

☐ Yes ☐ No

Have you fully recovered from pneumonia and have no further symptoms?

☐ Yes ☐ No

Have you been advised to have a follow-up Chest X-ray, CT-scan, MRI or other testing related to the lungs that has not been completed or that you are awaiting results?

☐ Yes ☐ No

Do you have any other lung or heart problems?

Explain:

☐ Pneumothorax (collapsed lung)

Did the pneumothorax occur within the past 6 months?

☐ Yes ☐ No

What was the cause of the pneumothorax?

- ☐ Spontaneous
- ☐ Trauma
- ☐ Other

Explain:

Have you fully recovered from the pneumothorax with no further symptoms?

- ☐ Yes ☐ No

☐ Pulmonary embolism (blood clot in lung)

Have you had more than one episode/event associated with a pulmonary embolism?

- ☐ Yes ☐ No

Have you had a pulmonary embolism within the past 2 years?

- ☐ Yes ☐ No

Do you require ongoing anticoagulant treatment (Coumadin or Warfarin) to prevent future blood clots?

- ☐ Yes ☐ No

Was the cause of the embolism due to another disease or disorder?

- ☐ Yes ☐ No

Explain:

☐ Pulmonary Hypertension

☐ Sarcoidosis

☐ Sleep Apnea

Were you diagnosed with sleep apnea within the past 6 months?

- ☐ Yes ☐ No

Have you been advised to use c-pap or bi-pap treatment?

☐ Yes ☐ No

Do you use recommended treatment?

☐ Yes ☐ No

Have you been advised to have a sleep study that has not yet been completed?

☐ Yes ☐ No

Do you currently suffer from excessive daytime fatigue?

☐ Yes ☐ No

☐ Lung cancer

☐ Other

Explain:

☐ Clotting or bleeding disorder, anemia or blood disease

Please indicate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as it relates to clotting or bleeding disorder, anemia or blood disease (select all that apply)

☐ Anemia

Have you been hospitalized for anemia in the past year?

☐ Yes ☐ No

Has your anemia caused you to receive a blood transfusion in the past 5 years?

☐ Yes ☐ No

Have you ever been diagnosed with cancer (excluding basal cell or squamous cell skin cancer), leukemia, lymphoma, multiple myeloma, or hemophilia or other bleeding/clotting disorder?

☐ Yes ☐ No

Have you been diagnosed with sickle cell anemia?

☐ Yes ☐ No

Have you been advised by a member of the medical profession that you have sickle cell trait only?

☐ Yes ☐ No

Have you ever been diagnosed with symptomatic sickle cell anemia or required any treatment for sickle cell anemia?

☐ Yes ☐ No

Was the cause of the anemia due to bleeding from the gastrointestinal tract?

☐ Yes ☐ No

Was the last occurrence of gastrointestinal bleeding within the past 2 years?

☐ Yes ☐ No

Was there any cancer or malignancy found to be the cause of the bleeding?

☐ Yes ☐ No

Have the symptoms fully resolved and anemia no longer present?

☐ Yes ☐ No

Have you had a colonoscopy with abnormal results in the past 2 years?

☐ Yes ☐ No

Have you been advised to have a colonoscopy or other testing involving the gastrointestinal tract that has not yet been completed?

☐ Yes ☐ No

☐ Other

Explain:

☐ Diabetes treated with insulin or requiring hospitalization

Please indicate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as it relates to diabetes treated with insulin or requiring hospitalization (select all that apply)

Have you been prescribed Insulin to treat your diabetes?

☐ Yes ☐ No

Have you been hospitalized in the past 5 years due to diabetes?

☐ Yes ☐ No

Have you ever been diagnosed with a diabetic coma in the past 10 years by a medical professional?

☐ Yes ☐ No

Have you been diagnosed by a member of the medical profession with heart disease, kidney disease, excessive protein or albumin in the urine, or blindness?

☐ Yes ☐ No

Have you had any limbs amputated due to diabetes or circulatory problems?

☐ Yes ☐ No

Have you ever required dialysis or been advised by a member of the medical profession that you need dialysis?

☐ Yes ☐ No

What was your most recent Hemoglobin A1c (HGB A1c, glycosylated hemoglobin) test result?

- ☐ 7.0 or less
☐ 7.1 - 9.99
☐ 10.0 or higher
☐ unknown

What was your most recent blood sugar test result?

- ☐ Below 145
☐ 145 to 220
☐ Over 220

Have you been prescribed oral medications or diet to treat your diabetes?

☐ Yes ☐ No

Have you been hospitalized in the past 5 years due to diabetes?

☐ Yes ☐ No

Have you ever been diagnosed with a diabetic coma in the past 10 years by a medical professional?

☐ Yes ☐ No

Have you had any limbs amputated due to diabetes or circulatory problems

☐ Yes ☐ No

Have you ever required dialysis or been advised by a member of the medical profession that you need dialysis?

☐ Yes ☐ No

What was your most recent Hemoglobin A1c (HGB A1c, glycosylated hemoglobin) test result?

- ☐ 7.0 or less
☐ 7.1 - 9.99
☐ 10.0 or higher
☐ unknown

What was your most recent blood sugar test result?

- ☐ Below 145
☐ 145 to 220
☐ Over 220

☐ High blood pressure requiring more than 2 medications or hospitalization

Please indicate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as it relates to high blood pressure requiring more than 2 medications or hospitalization (select all that apply)

In the past 6 months have you had a blood pressure reading over 160/100?

☐ Yes ☐ No

Have you ever been diagnosed with Stroke, Cerebral Vascular Accident (CVA), Transient Ischemic Attack (TIA), Heart Disease, Congestive Heart Failure, Peripheral Vascular disease, or disease or disorder of the heart valves?

☐ Yes ☐ No

Do you have any cardiac testing or procedures pending or advised to have completed that have not been completed?

☐ Yes ☐ No

Explain:

5

Within the past 10 years, have you been diagnosed or treated by a member of the medical profession for: heart attack, disease or abnormality of the heart or blood vessels, stroke, cerebral vascular accident (CVA), aneurysm, peripheral vascular disease, cancer (excluding basal and squamous cell skin cancer), leukemia, lymphoma, malignancy, nervous system disease or disorder, hepatitis C, kidney, liver, pancreas disease or disorder, Alzheimer's, schizophrenia, bipolar, mental disorder, or as having an acquired immune deficiency disease or disorder (AIDS), AIDS-Related Complex, or tested positive on an acquired immune deficiency syndrome-related test?

☐ Yes ☐ No

(Select all which are applicable):

☐ Heart attack or any disease or abnormality of the heart or blood vessels.

Please indicate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as it relates to heart attack or disease or abnormality of the heart or blood vessels. (Select all that apply):

- ☐ Heart Attack
- ☐ Stroke or Cerebral Vascular Accident (CVA)
- ☐ Coronary Artery Disease
- ☐ Coronary Bypass surgery, coronary angioplasty, or Stenting of coronary artery or arteries.
- ☐ Congestive Heart Failure
- ☐ Disease of the heart valve or valves
- ☐ Heart Murmur

Does your heart murmur cause any restrictions on activity?

☐ Yes ☐ No

Have you ever had any blackouts or fainting episodes due to your heart murmur?

☐ Yes ☐ No

Have you ever been diagnosed by a member of the medical profession with a disease or disorder of the heart valves?

☐ Yes ☐ No

Have you been diagnosed with Mitral Valve Prolapse (MVP)?

☐ Yes ☐ No

Does your Mitral Valve Prolapse cause any arrhythmias or palpitations or restrict activity in any way?

☐ Yes ☐ No

When was your most recent echocardiogram (ultrasound of heart)?

- ☐ within the last 6 months
- ☐ over 6 months ago
- ☐ never had an echocardiogram

Have you been advised to have an echocardiogram (ultrasound of heart) that has not yet been completed?

- ☐ Yes ☐ No

Do you have any other cardiac testing or procedures pending or advised to have completed that have not yet been completed?

- ☐ Yes ☐ No

Explain:

- ☐ Irregular heartbeat, palpitations, or arrhythmia
- ☐ High Blood Pressure or Hypertension
- ☐ Other

Explain:

- ☐ Stroke, cerebral vascular accident (CVA), aneurysm, or any peripheral vascular disease.
- ☐ Cancer (excluding basal and squamous cell skin cancer), leukemia, lymphoma, or any other malignancy.
- ☐ Acquired immune deficiency disease or disorder (AIDS), AIDS-Related Complex.
- ☐ Tested positive on an acquired immune deficiency syndrome-related test.
- ☐ Nervous system disorder or disease.

Please indicate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as it relates to nervous system disease or disorder. (Select all that apply):

- ☐ Dementia or cognitive disease or disorder
- ☐ Huntington's Disease
- ☐ Multiple Sclerosis
- ☐ Stroke or Cerebral Vascular Accident (CVA)
- ☐ Parkinson's Disease
- ☐ Amyotrophic Lateral Sclerosis (ALS) or Lou Gehrig's Disease
- ☐ Seizure disorder or epilepsy

Were you first diagnosed with seizure disorder or epilepsy within the past 2 years?

☐ Yes ☐ No

When was your last attack/episode of epilepsy or seizure?

- ☐ 0-3 years ago
☐ 3-7 years ago
☐ Over 7 years ago

Are you considered disabled due to seizure disorder or epilepsy?

☐ Yes ☐ No

Is seizure disorder or epilepsy caused by a brain or other nervous system tumor?

☐ Yes ☐ No

Do you have any testing or procedures that have been recommended by a member of the medical profession for seizure disorder or epilepsy that has not yet been completed?

☐ Yes ☐ No

Explain:

☐ Tremor

Has the tremor been present for less than 2 years?

☐ Yes ☐ No

Has the tremor been evaluated by a member of the medical profession and determined to be a benign, essential, or physiological tremor with no Parkinson's disease or other underlying cause?

☐ Yes ☐ No

Do you have any testing or procedures with respect to the tremor that have been recommended by a member of the medical profession that has not yet been completed?

☐ Yes ☐ No

Explain:

☐ Spinal Cord injury or disease

Please indicate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as it relates to spinal cord injury or disease (Select all that apply):

- ☐ Quadriplegia or tetraplegia
- ☐ Paraplegia or Paraparesis
- ☐ Hemiplegia or hemiparesis
- ☐ Non-paralyzing injury to spinal cord
- ☐ Spondylosis
- ☐ Herniated disc or compression of the spinal cord
- ☐ Other Spinal Cord disease, disorder or injury

Explain:

Do you currently use a wheel chair?

☐ Yes ☐ No

Do you currently require the use of narcotics to control pain?

☐ Yes ☐ No

Do you currently require walking aids?

☐ Yes ☐ No

Are you considered disabled due to the spinal cord injury or disease?

☐ Yes ☐ No

☐ Tumor of the nervous system or brain

Was the tumor considered cancerous or malignant?

☐ Yes ☐ No

Was the tumor a brain tumor?

☐ Yes ☐ No

Has the brain tumor been surgically removed?

☐ Yes ☐ No

Was the brain tumor removed within the past 10 years?

☐ Yes ☐ No

Do you have any neurological testing or procedure that has been recommended by a medical professional that has not yet been completed?

☐ Yes ☐ No

Explain:

Was the tumor a spinal cord tumor?

☐ Yes ☐ No

Was the tumor surgically removed

☐ Yes ☐ No

Was the tumor removed within the past 2 years?

☐ Yes ☐ No

Do you have any neurological testing or procedure that has been recommended by a medical professional that has not yet been completed?

☐ Yes ☐ No

Explain:

☐ Depression, Anxiety, or other psychological condition

Please indicate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as it relates to depression, anxiety, or other psychological condition: (Select all that apply):

☐ Bipolar

☐ Schizophrenia

☐ Depression

Have you been hospitalized for this condition in the past 5 years?

☐ Yes ☐ No

Have you ever attempted suicide?

☐ Yes ☐ No

Are you considered disabled due to this condition?

☐ Yes ☐ No

☐ Anxiety

Have you been hospitalized for this condition in the past 5 years?

☐ Yes ☐ No

Have you ever attempted suicide?

☐ Yes ☐ No

Are you considered disabled due to this condition?	
<input type="radio"/> Yes <input type="radio"/> No	
<input type="checkbox"/> Other Explain: <div></div>	
<input type="checkbox"/> Bells Palsy	
Have you been diagnosed by a member of the medical profession with Bells Palsy within the past 6 months?	
<input type="radio"/> Yes <input type="radio"/> No	
<input type="checkbox"/> Trigeminal Neuralgia	
Have you had surgery for trigeminal neuralgia?	
<input type="radio"/> Yes <input type="radio"/> No	
Have you fully recovered from the surgery?	
<input type="radio"/> Yes <input type="radio"/> No	
Has surgery been recommended that has not been completed?	
<input type="radio"/> Yes <input type="radio"/> No	
<input type="checkbox"/> Thoracic Outlet Syndrome	
<input type="checkbox"/> Narcolepsy	
Were you first diagnosed by a member of the medical profession with Narcolepsy within the past 2 years?	
<input type="radio"/> Yes <input type="radio"/> No	
Have you had any symptoms of narcolepsy in the past year?	
<input type="radio"/> Yes <input type="radio"/> No	
<input type="checkbox"/> Other nervous system disorder or disease	
Explain: <div></div>	
<input type="checkbox"/> Hepatitis C or any kidney, liver, pancreas disease or disorder.	

Please indicate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as it relates to hepatitis C or kidney, liver, pancreas disease or disorder. (Select all that apply):

☐ Kidney Disease

- ☐ Blockage of the renal (kidney) arteries
- ☐ Hypertensive renal (kidney) disease
- ☐ Cancer of the kidney
- ☐ Had dialysis or been advised to have dialysis?
- ☐ Kidney failure
- ☐ Glomerulonephritis, nephritic or nephrotic syndrome
- ☐ Polycystic kidney disease
- ☐ Kidney stones
- ☐ Kidney infection

Did your kidney infection occur in the past 3 months?

☐ Yes ☐ No

Have you fully recovered from your kidney infection

☐ Yes ☐ No

☐ Other

Explain:

☐ Hepatitis B or C

☐ Hepatitis A

Have you fully recovered from Hepatitis A?

☐ Yes ☐ No

- ☐ Non-viral hepatitis
- ☐ Enlarged liver
- ☐ Cirrhosis of the liver
- ☐ Primary Biliary Cirrhosis
- ☐ Primary Sclerosing Cholangitis
- ☐ Liver tumor or liver cancer

☐ Fatty liver

Have you been advised by member of the medical profession that your liver enzymes or liver function tests are abnormal or elevated?

☐ Yes ☐ No

Have you been advised by a member of the medial profession that the cause of fatty liver is related to alcohol use?

☐ Yes ☐ No

Have you had a liver biopsy or has a liver biopsy been recommended by a member of the medical profession?

☐ Yes ☐ No

Have you been diagnosed by a member of the medical profession with Non-Alcoholic Steatohepatitis (NASH)?

☐ Yes ☐ No

☐ Pancreatitis

☐ Tumor or Cancer of the Pancreas

☐ Crohn's or ulcerative colitis

Do you use steroids or immunosuppressive drugs for treatment?

☐ Yes ☐ No

Have you been hospitalized for Crohn's or ulcerative colitis in the past 5 years?

☐ Yes ☐ No

Did you require surgery or have you been advised by a member of the medical profession to have surgery for Crohn's or ulcerative colitis which has not been performed?

☐ Yes ☐ No

Have you had an attack of Crohn's or ulcerative colitis within the past year?

☐ Yes ☐ No

Does Crohn's or ulcerative colitis limit normal activity or are you considered disabled due to this condition?

☐ Yes ☐ No

Has a member of the medical profession advised you to have a colonoscopy or other test related to the gastrointestinal tract that has not been completed?

☐ Yes ☐ No

☐ Other

Explain:

☐ Alzheimer's, schizophrenia, bipolar or mental disorder.

Please indicate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as it relates to alzheimer's, schizophrenia, bipolar or mental disorder (select all that apply) :

☐ Alzheimer's
☐ Schizophrenia
☐ Bipolar
☐ Attempted Suicide
☐ Depression

Have you been hospitalized for this condition in the past 5 years?

☐ Yes
☐ No

Have you ever attempted suicide?

☐ Yes
☐ No

Are you considered disabled due to this condition?

☐ Yes
☐ No

☐ Anxiety

Have you been hospitalized for this condition in the past 5 years?

☐ Yes
☐ No

Have you ever attempted suicide?

☐ Yes
☐ No

Are you considered disabled due to this condition?

☐ Yes
☐ No

☐ Other

Explain:

CONTINUE

Copyright 2012 AMERICAN NATIONAL INSURANCE COMPANY. All Rights Reserved.

American National Insurance Company, is headquartered at One Moody Plaza, Galveston TX 77550 and is licensed to conduct business in all states except New York. Business is conducted in New York by American National Life Insurance Company of New York, 344 Route 9W P.O. Box 505 Glenmont, NY 12077

Policies contain exclusions, limitation and terms for keeping them in force.



10582-I

If med question decline:



877.698.0987



Live Support
ONLINE

[ABOUT US](#) | [FAQS](#) | [PRIVACY](#) | [CONTACT US](#)

1

GET A QUOTE & CHOOSE COVERAGE

2

APPLY FOR INSTANT COVERAGE

3

PAYMENT OPTIONS

We're sorry, based on the information provided, the application process can not be completed online. If you would like to submit an application for consideration, please click the "Print Application" below, complete the application, make sure it's signed by the person to be covered, and mail it to:

American National Life Insurance Company
P.O. Box 696700
San Antonio, TX 78269

Note: You **MUST** have Adobe Acrobat Reader 5.0 or higher installed on your computer to view the online application. You may click on the "Get Acrobat Reader" logo to obtain a Free copy.

Click here to ["Print your application"](#).

Copyright 2012 AMERICAN NATIONAL INSURANCE COMPANY. All Rights Reserved.

American National Insurance Company, is headquartered at One Moody Plaza, Galveston TX 77550 and is licensed to conduct business in all states except New York. Business is conducted in New York by American National Life Insurance Company of New York, 344 Route 9W P.O. Box 505 Glenmont, NY 12077

Policies contain exclusions, limitation and terms for keeping them in force.



10582-I

Disclosure Page



877.698.0987



Live Support
ONLINE

[ABOUT US](#) | [FAQS](#) | [PRIVACY](#) | [CONTACT US](#)

1 GET A QUOTE & CHOOSE COVERAGE

2 APPLY FOR INSTANT APPROVAL

3 PAYMENT OPTIONS

STEP-2: Notice of Information Practices and Electronic Consent

You are 60% complete

Print Disclosures

Please review all disclosures carefully and agree to the following: Exchange of Information, MIB Pre-notifications, Fair Credit Act Pre-notification, USA PATRIOT Act Notice, Consent For Use Of Electronic Signatures and Statement of Electronic Disclosures:

See screen_appendix A for Call Center Path Disclosures

See screen_appendix B for Internet (Consumer) Path Disclosures

DECLINE

AGREE

Copyright 2012 AMERICAN NATIONAL INSURANCE COMPANY. All Rights Reserved.

American National Insurance Company, is headquartered at One Moody Plaza, Galveston TX 77550 and is licensed to conduct business in all states except New York. Business is conducted in New York by American National Life Insurance Company of New York, 344 Route 9W P.O. Box 505 Glenmont, NY 12077

Policies contain exclusions, limitation and terms for keeping them in force.



10582-I

If decline –



877.698.0987



Live Support
ONLINE

[ABOUT US](#) | [FAQS](#) | [PRIVACY](#) | [CONTACT US](#)

1

GET A QUOTE & CHOOSE COVERAGE

2

APPLY FOR INSTANT COVERAGE

3

PAYMENT OPTIONS

[Application process options](#)

Without the required acceptance of the Notice of Information Practices and Electronic Consent, we cannot continue online processing of your application.

- ☐ **Option 1:** Continue with electronic process.
- ☐ **Option 2:** I would prefer to print my application, sign it, and send it to American National Insurance Company. I understand that, if approved, I will receive my policy in the mail and that I must remit my initial premium before any insurance will go into effect.
- ☐ **Option 3:** Please discontinue processing my application. I understand that I may return at a future date and apply again but I will have to complete a new application at that time.

CONTINUE



Copyright 2012 AMERICAN NATIONAL INSURANCE COMPANY. All Rights Reserved.

American National Insurance Company, is headquartered at One Moody Plaza, Galveston TX 77550 and is licensed to conduct business in all states except New York. Business is conducted in New York by American National Life Insurance Company of New York, 344 Route 9W P.O. Box 505 Glenmont, NY 12077


Policies contain exclusions, limitation and terms for keeping them in force.





10582-I

Ex opt 1 – go to Disclosure Page

Ex opt 2 –



 877.698.0987

 Live Support
ONLINE

ABOUT US | FAQs | PRIVACY | CONTACT US

1 GET A QUOTE & CHOOSE COVERAGE

2 APPLY FOR INSTANT COVERAGE

3 PAYMENT OPTIONS

Important Reminder!

Processing can't begin until we receive your signed application.

Note: You MUST have Adobe Acrobat Reader® 5.0 or higher installed on your computer to view the online application. You may click [here](#) to obtain a FREE copy.

Please click [here](#) to see your application. Then review, print, sign, date and mail it to American National Insurance Company at the following address:







American National Insurance Company
P.O. BOX 696700
San Antonio, TX 78269

Your application, will be processed immediately upon receipt and, once approved, your policy will be mailed. The next screen will present the application as you've completed it to this point. Please don't delay - print and mail your application today! Thank you for considering American National Insurance Company for your life insurance needs. We look forward to receiving your application soon.


Copyright 2012 AMERICAN NATIONAL INSURANCE COMPANY. All Rights Reserved.


American National Insurance Company, is headquartered at One Moody Plaza, Galveston TX 77550 and is licensed to conduct business in all states except New York. Business is conducted in New York by American National Life Insurance Company of New York, 344 Route 9W P.O. Box 505 Glenmont, NY 12077


Policies contain exclusions, limitation and terms for keeping them in force.



10582-I

Ex opt 3 –



 877.698.0987

 Live Support
ONLINE

ABOUT US | FAQs | PRIVACY | CONTACT US

1 GET A QUOTE & CHOOSE COVERAGE

2 APPLY FOR INSTANT COVERAGE

3 PAYMENT OPTIONS







Thank You!

Thank you for considering American National Insurance Company for your life insurance needs. We're sorry we were unable to meet your needs at this time but we hope you will return to our site the next time you consider providing financial security for your family.

Copyright 2012 AMERICAN NATIONAL INSURANCE COMPANY. All Rights Reserved.

American National Insurance Company, is headquartered at One Moody Plaza, Galveston TX 77550 and is licensed to conduct business in all states except New York. Business is conducted in New York by American National Life Insurance Company of New York, 344 Route 9W P.O. Box 505 Glenmont, NY 12077

Policies contain exclusions, limitation and terms for keeping them in force.



10582-I

If agree from Disclosure Page – App is scrollable to review entire app (top of app)



877.698.0987



Live Support
ONLINE

[ABOUT US](#) | [FAQS](#) | [PRIVACY](#) | [CONTACT US](#)

1 GET A QUOTE & CHOOSE COVERAGE

2 APPLY FOR INSTANT COVERAGE

3 PAYMENT OPTIONS

STEP-2: Electronic Signature

Electronic signature must be completed.

You are 70% complete

e-Signature Process:

On the next several screens you will be prompted to add your electronic signature to the application and any other related documents and/or disclosures. Please review each document carefully for accuracy, completeness and to make sure that you understand and agree. By clicking on the sign button below, you will be agreeing to all terms & conditions described in each document. This will result in an enforceable legal document, just as if you had signed your name to a paper agreement. Failure to sign all of the items will result in our being unable to process your application online. You will still be eligible for this valuable coverage but we will have to delay the start until we can complete all of the requirements by mail.

Application For Individual Life Insurance		American National Insurance Company P.O. Box 696700 San Antonio, TX 78269	
Your Details:		Your Spouse's Details (if applying):	
Name: Mr. Edward Paul		Name: _____	
Address: 123 Main Street Apt. _____		Address: _____ Apt. _____	
City: Houston State: TX Zip Code: 77002		City: _____ State: _____ Zip Code: _____	
Phone #1: (409) 111-1111 Phone #2: (409) 111-1111		Phone #1: () _____ Phone #2: () _____	
E-mail: na@na.com		E-mail: _____	
Social Security Number: 123 - 45 - 6789		Social Security Number: _____ - _____ - _____	
Date of Birth: 04 / 05 / 1979		Date of Birth: _____ / _____ / _____	
<input type="checkbox"/> Female <input checked="" type="checkbox"/> Male Height: 6 ft. 01 in. Weight: 210		<input type="checkbox"/> Female <input type="checkbox"/> Male Height: _____ ft. _____ in. Weight: _____	
Are you a U.S. Citizen? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Are you a U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If 'No', do you have a permanent residence status? <input type="checkbox"/> Yes <input type="checkbox"/> No		If 'No', do you have a permanent residence status? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Annual Household Income: <input type="checkbox"/> Under \$10,000 <input type="checkbox"/> \$10,000 - \$24,999		Annual Household Income: <input type="checkbox"/> Under \$10,000 <input type="checkbox"/> \$10,000 - \$24,999	
<input type="checkbox"/> \$25,000 - \$49,999 <input type="checkbox"/> \$50,000 - \$99,999 <input checked="" type="checkbox"/> \$100,000+		<input type="checkbox"/> \$25,000 - \$49,999 <input type="checkbox"/> \$50,000 - \$99,999 <input type="checkbox"/> \$100,000+	
Marital Status: <input type="checkbox"/> Single <input checked="" type="checkbox"/> Married		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married	
Have you smoked cigarettes in the last 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Have you smoked cigarettes in the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	

E-SIGN AND CONTINUE

Copyright 2012 AMERICAN NATIONAL INSURANCE COMPANY. All Rights Reserved.

American National Insurance Company, is headquartered at One Moody Plaza, Galveston TX 77550 and is licensed to conduct business in all states except New York. Business is conducted in New York by American National Life Insurance Company of New York, 344 Route 9W P.O. Box 505 Glenmont, NY 12077

Policies contain exclusions, limitation and terms for keeping them in force.



10582-I

Bottom of app... cont...



**877.698.0987**

**Live Support**
ONLINE

ABOUT US | FAQs | PRIVACY | CONTACT US

1 GET A QUOTE & CHOOSE COVERAGE

2 APPLY FOR INSTANT COVERAGE

3 PAYMENT OPTIONS

STEP-2: Electronic Signature
Electronic signature must be completed.

You are 70% complete

e-Signature Process:

On the next several screens you will be prompted to add your electronic signature to the application and any other related documents and/or disclosures. Please review each document carefully for accuracy, completeness and to make sure that you understand and agree. By clicking on the sign button below, you will be agreeing to all terms & conditions described in each document. This will result in an enforceable legal document, just as if you had signed your name to a paper agreement. Failure to sign all of the items will result in our being unable to process your application online. You will still be eligible for this valuable coverage but we will have to delay the start until we can complete all of the requirements by mail.

I understand and agree: that the answers in this application are, to the best of my knowledge and belief, complete and true; that the answers will be relied upon to determine if coverage will be issued and the amount of premium that will be charged and will become a part of the Policy; that any material misstatement or omissions may cause the policy to be void; that the Company will have no liability until a policy is issued and the first premium due is paid in full while I am alive and in the same health condition as described above; that if my spouse and I request life insurance on this application that my personal financial and health information written on it will be made part of the policy issued to not only me but also my spouse; and that if I do not agree, I may contact the Company and receive a separate application.

I authorize any physician, medical practitioner, hospital, clinic, pharmacy, pharmacy benefit manager or other medical-related facility, insurance company, MIB, Inc. or other organization that has any records concerning health or medical care, advice or treatment provided to me to give any such information to American National Insurance Company, or to any agent or agency acting on its behalf or to its reinsurer(s). I authorize the Company, or its reinsurers, to make a brief report of my personal health information to MIB.

Your Signature: X  Edward Paul

Date: X 01 / 01 / 2013

Inc. I understand: that the Company will use this information to determine my eligibility for life insurance and the premium amount; that I may refuse to sign this authorization and that my refusal will affect my ability to obtain insurance; that such information may be subject to redisclosure and if so may no longer be protected by federal privacy law; that this authorization shall be valid for 24 months from the date signed and a copy will be as valid as the original; and that I have the right to revoke this authorization at any time, except to the extent that action has been taken in reliance thereon, by sending written notice to: the Company at the above address.

- I have read the Consumer Disclosure on the Sale of Insurance accompanying this application.
- I acknowledge receiving the Exchange of Information Notice.
- I have received and read the Summary and Disclosure Notice for Accelerated Benefits.
- **Fraud Warning:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Your Spouse's Signature: X _____

Date: X ____ / ____ / ____

E-SIGN AND CONTINUE 

Copyright 2012 AMERICAN NATIONAL INSURANCE COMPANY. All Rights Reserved.

American National Insurance Company, is headquartered at One Moody Plaza, Galveston TX 77550 and is licensed to conduct business in all states except New York. Business is conducted in New York by American National Life Insurance Company of New York, 344 Route 9W P.O. Box 505 Glenmont, NY 12077

Policies contain exclusions, limitation and terms for keeping them in force.





10582-I

Approve –



877.698.0987

Live Support
ONLINE

[ABOUT US](#) | [FAQS](#) | [PRIVACY](#) | [CONTACT US](#)

1 GET A QUOTE & CHOOSE COVERAGE

2 APPLY FOR INSTANT COVERAGE

3 PAYMENT OPTIONS

STEP-2: Approved

You are 80% complete

[Congratulations! You've been approved!](#)

Your new policy number is D400xxxxx. Your policy will be mailed to you and you can expect to receive it in 5 to 7 days.

Great news, you are almost done! Please click the continue button to complete the online payment process so your valuable coverage can go into effect quickly.

CONTINUE

Copyright 2012 AMERICAN NATIONAL INSURANCE COMPANY. All Rights Reserved.

American National Insurance Company, is headquartered at One Moody Plaza, Galveston TX 77550 and is licensed to conduct business in all states except New York. Business is conducted in New York by American National Life Insurance Company of New York, 344 Route 9W P.O. Box 505 Glenmont, NY 12077

Policies contain exclusions, limitation and terms for keeping them in force.



10582-I

RTU



877.698.0987

Live Support
ONLINE

[ABOUT US](#) | [FAQS](#) | [PRIVACY](#) | [CONTACT US](#)

1 GET A QUOTE & CHOOSE COVERAGE

2 APPLY FOR INSTANT COVERAGE

3 PAYMENT OPTIONS

STEP-2: Referred to an Underwriter

You are 80% complete

[Application Referred to Underwriter](#)

Thank you for your application. Your new policy number is D400xxxxx. It has been referred to an underwriter for further evaluation. To avoid delays, please proceed and select your payment option. Be assured that nothing will be charged or deducted until your policy has been approved. You will be hearing from us in the next few days regarding the results of the review process.

CONTINUE


Copyright 2012 AMERICAN NATIONAL INSURANCE COMPANY. All Rights Reserved.

American National Insurance Company, is headquartered at One Moody Plaza, Galveston TX 77550 and is licensed to conduct business in all states except New York. Business is conducted in New York by American National Life Insurance Company of New York, 344 Route 9W P.O. Box 505 Glenmont, NY 12077

Policies contain exclusions, limitation and terms for keeping them in force.



10582-I

 Application For Individual Life Insurance		American National Insurance Company P.O. Box 696700 San Antonio, TX 78269	
Your Details: Name: <u>Mr. Edward Paul</u> Address: <u>123 Main Street</u> City: <u>Little Rock</u> State: <u>AR</u> Zip Code: <u>72201</u> Phone #1: (<u>501</u>) <u>111-1111</u> Phone #2: (<u>501</u>) <u>111-1111</u> E-mail: <u>na@na.com</u> Social Security Number: <u>123</u> - <u>45</u> - <u>6789</u> Date of Birth: <u>04</u> / <u>05</u> / <u>1979</u> <input type="checkbox"/> Female <input checked="" type="checkbox"/> Male Height: <u>6</u> ft. <u>01</u> in. Weight: <u>210</u> Are you a U.S. Citizen? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If 'No', do you have a permanent residence status? <input type="checkbox"/> Yes <input type="checkbox"/> No Annual Household Income: <input type="checkbox"/> Under \$10,000 <input type="checkbox"/> \$10,000 - \$24,999 <input type="checkbox"/> \$25,000 - \$49,999 <input checked="" type="checkbox"/> \$50,000 - \$99,999 <input type="checkbox"/> \$100,000+ Marital Status: <input type="checkbox"/> Single <input checked="" type="checkbox"/> Married Have you smoked cigarettes in the last 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Occupation: <u>franchise owner</u>		Your Spouse's Details (if applying): Name: _____ Address: _____ City: _____ State: _____ Zip Code: _____ Phone #1: (____) _____ Phone #2: (____) _____ E-mail: _____ Social Security Number: _____ - _____ - _____ Date of Birth: ____ / ____ / ____ <input type="checkbox"/> Female <input type="checkbox"/> Male Height: ____ ft. ____ in. Weight: ____ Are you a U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No If 'No', do you have a permanent residence status? <input type="checkbox"/> Yes <input type="checkbox"/> No Annual Household Income: <input type="checkbox"/> Under \$10,000 <input type="checkbox"/> \$10,000 - \$24,999 <input type="checkbox"/> \$25,000 - \$49,999 <input type="checkbox"/> \$50,000 - \$99,999 <input type="checkbox"/> \$100,000+ Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married Have you smoked cigarettes in the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No Occupation: _____	
Your Amount of Coverage & Beneficiary: Plan: <u>BudgetGuard 7 Year Term</u> Amount (choose one): <input type="checkbox"/> \$250,000 <input type="checkbox"/> \$150,000 <input type="checkbox"/> \$100,000 <input checked="" type="checkbox"/> Other: \$ <u>25,000.00</u> Beneficiary: _____ Date of Birth: <u>03</u> / <u>10</u> / <u>1980</u> Relationship: <u>Spouse</u> Automatic Premium Loan Provision Requested? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No IMPORTANT: Do you intend to replace, discontinue, or change any existing life insurance policy? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If 'Yes', name of company and policy number(s) if available: _____		Your Spouse's Coverage & Beneficiary: Plan: _____ Amount (choose one): <input type="checkbox"/> \$250,000 <input type="checkbox"/> \$150,000 <input type="checkbox"/> \$100,000 <input type="checkbox"/> Other: \$ _____ Beneficiary: _____ Date of Birth: ____ / ____ / ____ Relationship: _____ Automatic Premium Loan Provision Requested? <input type="checkbox"/> Yes <input type="checkbox"/> No IMPORTANT: Do you intend to replace, discontinue, or change any existing life insurance policy? <input type="checkbox"/> Yes <input type="checkbox"/> No If 'Yes', name of company and policy number(s) if available: _____	
Your Health: 1. Within the past 10 years, have you been diagnosed or treated by a member of the medical profession for: heart attack, disease or abnormality of the heart or blood vessels, stroke, cerebral vascular accident (CVA), aneurysm, peripheral vascular disease, cancer (excluding basal and squamous cell skin cancer), leukemia, lymphoma, malignancy, nervous system disease or disorder, hepatitis C, kidney, liver, pancreas disease or disorder, Alzheimer's, schizophrenia, bipolar, mental disorder, or as having an acquired immune deficiency disease or disorder (AIDS), AIDS-Related Complex, or tested positive on an acquired immune deficiency syndrome-related test? You <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Your Spouse's Health (if applying): Your Spouse <input type="checkbox"/> Yes <input type="checkbox"/> No	

continued on back...

ADLAXXX(F)

Your Health:	Your Spouse's Health (if applying):
<p>2. Within the past 5 years, have you been: Diagnosed or treated by a member of the medical profession for a seizure or transient ischemic attack (TIA), hospitalized for depression or attempted suicide, diagnosed or treated by a member of the medical profession or received treatment or counseling for alcoholism, alcohol abuse or drug abuse, convicted of driving while intoxicated (DWI) or driving under the influence (DUI), convicted of a felony or been in prison?</p> <p>You <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>	<p>Your Spouse <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>3. Are you currently admitted to or confined to a hospital, mental institution, nursing home, assisted living center or receiving home health care or need assistance with eating, bathing or dressing?</p> <p>You <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>	<p>Your Spouse <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>4. Within the past 10 years, have you been diagnosed or treated by a member of the medical profession for: musculoskeletal disorder, lupus, connective tissue disease, lung disease or disorder, clotting or bleeding disorder, anemia or blood disease, diabetes treated with insulin or requiring hospitalization, high blood pressure requiring more than 2 medications or hospitalization? If "Yes", provide details below (dates of treatment, test results, diagnoses, medications, etc.)</p> <p>You <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Details: _____</p> <p>_____</p> <p>_____</p>	<p>Your Spouse <input type="checkbox"/> Yes <input type="checkbox"/> No Details: _____</p> <p>_____</p> <p>_____</p>
<p>5. Within the past 60 days, have you been advised by a member of the medical profession to get specified medical care which has not yet been completed or are still awaiting results, such as any hospitalization, surgery or diagnostic test, except those tests related to the Human Immunodeficiency Virus (AIDS virus)? If "Yes", provide details below:</p> <p>You <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Details: _____</p> <p>_____</p> <p>_____</p>	<p>Your Spouse <input type="checkbox"/> Yes <input type="checkbox"/> No Details: _____</p> <p>_____</p> <p>_____</p>
<p><i>If you have more details, please include them on a separate sheet of paper</i></p>	
<p>Your Payment — choose one:</p>	
<p>I/we authorize the collection of premiums for the policy or policies as follows.</p> <p>1. <input checked="" type="checkbox"/> Automatic monthly deductions from my checking or savings account. (Enclose a voided check when providing checking account and a deposit slip when providing savings account.)</p> <p>2. <input type="checkbox"/> Charge monthly premiums to my: <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> Discover / </p> <p>3. <input type="checkbox"/> Bill me/us. (Send no money now.) (Account Number) (Exp. Date)</p>	
<p>Agreements and Your Authorization to Obtain, Release and Disclose Medical Information:</p>	
<p>I understand and agree: that the answers in this application are, to the best of my knowledge and belief, complete and true; that the answers will be relied upon to determine if coverage will be issued and the amount of premium that will be charged and will become a part of the Policy; that any material misstatement or omissions may cause the policy to be void; that the Company will have no liability until a policy is issued and the first premium due is paid in full while I am alive and in the same health condition as described above; that if my spouse and I request life insurance on this application that my personal financial and health information written on it will be made part of the policy issued to not only me but also my spouse; and that if I do not agree, I may contact the Company and receive a separate application.</p> <p>I authorize any physician, medical practitioner, hospital, clinic, pharmacy, pharmacy benefit manager or other medical-related facility, insurance company, MIB, Inc. or other organization that has any records concerning health or medical care, advice or treatment provided to me to give any such information to American National Insurance Company, or to any agent or agency acting on its behalf or to its reinsurer(s). I authorize the Company, or its reinsurers, to make a brief report of my personal health information to MIB, Inc. signed 01/01/2013 by</p> <p>Your Signature: X <u>Edward Paul</u></p> <p>Date: X <u>01</u> / <u>01</u> / <u>2013</u></p>	<p>Inc. I understand: that the Company will use this information to determine my eligibility for life insurance and the premium amount; that I may refuse to sign this authorization and that my refusal will affect my ability to obtain insurance; that such information may be subject to redisclosure and if so may no longer be protected by federal privacy law; that this authorization shall be valid for 24 months from the date signed and a copy will be as valid as the original; and that I have the right to revoke this authorization at any time, except to the extent that action has been taken in reliance thereon, by sending written notice to: the Company at the above address.</p> <ul style="list-style-type: none"> • I have read the Consumer Disclosure on the Sale of Insurance accompanying this application. • I acknowledge receiving the Exchange of Information Notice. • I have received and read the Summary and Disclosure Notice for Accelerated Benefits. • Fraud Warning: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. <p>Your Spouse's Signature: X _____</p> <p>Date: X ____ / ____ / ____</p>

ADLXXX(B)

Screen appendix B – Internet (Customer) Path

You have now provided the personal information needed to evaluate your insurance application. Before we can complete your application review, we must ask you to read and accept certain disclosures about our information practices and provide us with any necessary authorizations. These disclosures begin below.

Exchange of Information Notice

We are required to provide you the following disclosures to you:

Medical Information Bureau, Inc. (MIB) Pre-Notification

Information regarding your insurability will be treated as confidential. American National Insurance Company, or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

American National Insurance Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

Fair Credit Reporting Act Pre-notification

We may obtain an investigative consumer report in connection with your application. This report may contain information about your character, general reputation, personal characteristics or mode of living gathered from personal interviews with persons who may be acquainted with you. The information is kept confidential.

You have the right to additional information about the nature and scope of the investigation provided you submit your request in writing within a reasonable period of time. We will inform you whether an investigative consumer report was requested and provide you with contact information for the agency preparing the report. By contacting the agency and providing proper identification, you may inspect or receive a copy of such report. A summary of your rights may be found on the Internet at www.ftc.gov/credit.

USA PATRIOT Act Notice

The USA PATRIOT Act requires that we establish an Anti-Money Laundering (AML) Program, notify customers that we must verify the identity of the owner(s) of our contracts that have cash value, and collect information sufficient to verify identity. Failure to provide us identification information may result in the delay of issuance of coverage and may result in a decision not to accept your business.

Consent For Use Of Electronic Signatures and Records - Before we can process your application online, we will need you to sign it together with certain other documents. This process will bind your electronic "signature" to these documents such that no changes can ever be made to the information you provided without invalidating your signature. This provides you with the assurance that any information you provide will be retained exactly as you provided it - guaranteed! Also, please be assured that all of your information is subject to our strictest security and privacy standards. Click on the Security & Privacy link below for more information. Please read and acknowledge your consent to use electronic signatures and agreement to receive required notices and documents electronically.

Consent for use of electronic signatures and records:

American National Insurance Company is required by law to provide you with certain disclosures and information about your life insurance application ("Required Information"). With your consent, American National Insurance Company can deliver Required Information to you by: Displaying or delivering the Required Information electronically, and Requesting that you print or download the Required Information and retain it for your records.

This notice contains important information that you are entitled to receive before you consent to electronic delivery of required information. Your consent also permits the general use of electronic records and electronic signatures in connection with your application. Please read this notice carefully and print or download a copy for your files.

After you have read this information, if you agree to receive Required Information from American National Insurance Company electronically, and if you agree to the general use of electronic records and electronic signatures in connection with your relationship with American National Insurance Company, please click on the "Accept" button at the bottom.

Statement of electronic disclosures:

You may request to receive Required Information on paper, but if you do not consent to electronic delivery of Required Information, American National Insurance Company cannot proceed with the acceptance and processing of your electronic application.

If you consent to electronic delivery of Required Information, you may withdraw that consent at any time. However, if you withdraw your consent we will not be able to continue processing your application.

If you consent to electronic disclosures, that consent applies to all Required Information American National Insurance Company gives you or receives from you in connection with your life insurance application and the associated notices, disclosures, and other documents.

The Required Information that may covered by the consent includes, among other things:

Medical Information Bureau (MIB) Pre-Notification	Notice of Insurance Information Practices
Authorization to release personal health information	Notices regarding policy replacement and adverse underwriting decisions

You agree to print out or download Required Information when we advise you to do so and keep it for your records. If you have any trouble printing out or downloading any Required Information, you may call American National Insurance Company at 1-877-697-0098 Monday through Friday from 9 a.m. to 7 p.m. Eastern Time and request paper copies. If you need to update your e-mail address or other contact information with American National Insurance Company, you may do so by calling us at 1-877-697-0098 Monday through Friday from 9 a.m. to 7 p.m. Eastern Time or by clicking on the Contact Us link at the bottom and sending the required information via email. Upon receipt, we will update your records.

If you wish to withdraw your consent to electronic disclosures, you may do so by calling us at 1-877-697-0098 Monday through Friday from 9 a.m. to 7 p.m. Eastern Time or by clicking on the Contact Us link at the bottom and sending the request via email. After consenting to receive and deliver Required Information electronically, you may, upon request, obtain a paper copy of the Required Information by calling 1-877-697-0098 Monday through Friday from 9 a.m. to 7 p.m. Eastern Time.

Software and Hardware Requirements:

To access and retain Required Information from American National Insurance Company, you must:

1. Be able to view the disclosures on your monitor and send screen prints to your printer, which can be done with your browser.
2. Have access to an Internet service account and use Internet Explorer V4.0 and above or Netscape Navigator V4.x and above to receive required information
3. Be able to send and receive e-mail that contains hyperlinks to Websites in order for American National Insurance Company to deliver required information to you

If you do not have the required software and/or hardware, or if you do not wish to use electronic records and signatures for any other reason, you can request paper copies of the application document(s) to be sent to you by clicking on the Contact Us link at the bottom and sending us your request.


Your consent does not mean that American National Insurance Company must provide the Required Information electronically. American National Insurance Company may, at their option, deliver Required Information on paper if it chooses to do so. American National Insurance Company may also require that certain communications from you be delivered to American National Insurance Company on paper at a specified address.

I have read the information about the use of electronic records, disclosures, notices, and e-mail, and consent to the use of electronic records for the delivery of required information in connection with my life insurance application with American National Insurance Company. I have been able to view this information using my computer and software. I have an account with an internet service provider, and I am able to send e-mail and receive e-mail with hyperlinks to websites and attached files. I also consent to the use of electronic records and electronic signatures in connection with my life insurance application with American National Insurance Company in place of written documents and

handwritten signatures. I am consenting on behalf of all joint applicants identified in the application. I am authorized to consent on their behalf.

Appendix C -

Website template subject to change (indicated in red boxes below – header and footer):



877.698.0987Live Support
ONLINE

ABOUT US | FAQs | PRIVACY | CONTACT US

1 GET A QUOTE & CHOOSE COVERAGE

2 APPLY FOR INSTANT COVERAGE

3 PAYMENT OPTIONS

STEP-2: Apply For Instant Coverage

You are 20% complete

All asterisked * fields must be completed.

Copyright 2012 AMERICAN NATIONAL INSURANCE COMPANY. All Rights Reserved.

American National Insurance Company, is headquartered at One Moody Plaza, Galveston TX 77550 and is licensed to conduct business in all states except New York. Business is conducted in New York by American National Life Insurance Company of New York, 344 Route 9W P.O. Box 505 Glenmont, NY 12077

Policies contain exclusions, limitation and terms for keeping them in force.

VISA DISCOVER AMERICAN EXPRESS PayPal

digicert SECURED SSL CERTIFICATES

This Page is Secured

10582-I